

THE  
AMERICAN  
MEDICAL DIGEST.

ISSUED IN MONTHLY PARTS.

*BIBLIOGRAPHY OF CURRENT MEDICAL LITERATURE,  
ABSTRACTS AND REVIEWS,—IN THREE PARTS,  
MEDICINE, SURGERY, DISEASES OF  
WOMEN AND CHILDREN  
AND OBSTETRICS.*

EDITED BY

JOHN C. LESTER, A.M., M.D.

*CONTRIBUTORS.*

ALEXANDER J. C. SKENE, M. D.,

Professor of the Medical and Surgical Diseases of Women  
and Diseases of Children, Long Island  
College Hospital.

ARTHUR MATHEWSON, M. D.

Professor of Ophthalmology, Long Island College Hos-  
pital; Surgeon to Brooklyn Eye and Ear Hospital.

JOHN C. SHAW, M. D.,

Superintendent of Kings County Lunatic Asylum.

F. R. STURGIS, M. D.,

Professor Venereal Diseases, University of New York.  
President N. Y. County Medical Society;  
Visiting Surgeon to Charity Hospital.

GEORGE HENRY FOX, M. D.,

Clinical Professor of Diseases of the Skin, College  
Physicians and Surgeons, New York.

CHARLES JEWETT, M. D.,

Professor Obstetrics, Long Island College Hospital;  
President Kings County Medical Society.

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1883.

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NEW YORK:

H. CAMPBELL & CO., PUBLISHERS.

140 and 142 NASSAU STREET.

*Sturges*

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PRINTED BY P. F. MCBREEN.  
16 BEEKMAN ST., NEW YORK.

THE AMERICAN MEDICAL DIGEST.

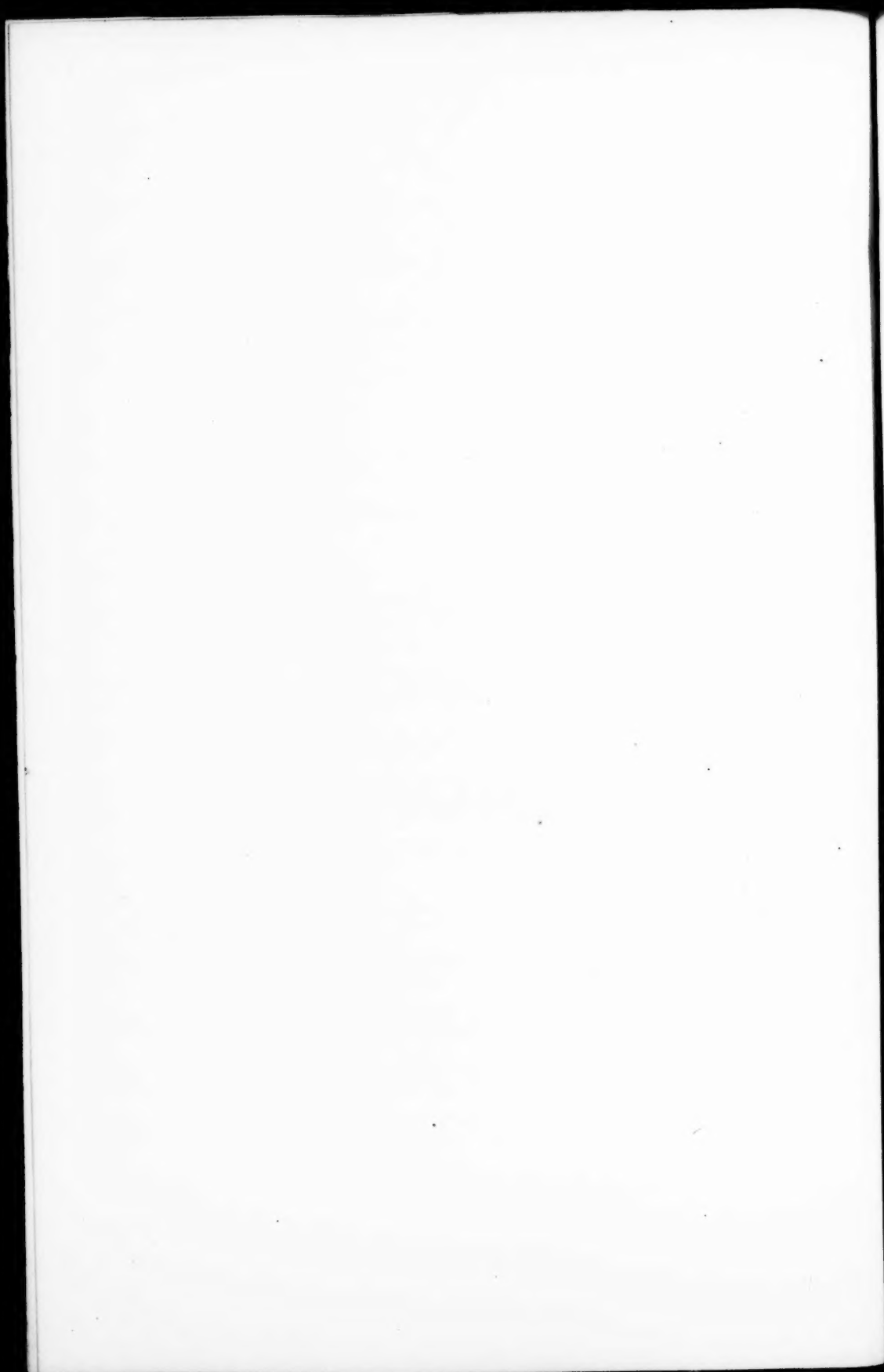
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PART I.

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MEDICINE.

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# THE AMERICAN MEDICAL DIGEST.

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VOLUME II.

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## MEDICINE.

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### CONSTITUTIONAL DISEASES.

#### A New Theory as to the Pathogeny of Rheumatism.

In an article entitled "Rheumathritis, Carditis, and Chorea, with a New Theory of their Unity of Origin," Dr. W. STEWART, of Barnsley (*British Medical Journal*), broaches an ingenious theory with regard to the causation of these associated affections, that agrees apparently with many of the clinical features which have been hitherto unexplained. The central idea in his hypothesis is that the lesions termed rheumatic are due to a primary disorder of the blood or of its constituents, and that this offending agent is a white blood-cell in a pathological condition due to partial devitalization, somewhat analogous to tuberculosis and pyæmia, which he regards as merely greater degrees of devitalization of these cells. The most prolific source for these rheumatic leucocytes is in the tonsils, which are frequently observed to be inflamed prior to the appearance of the other symptoms. Either class of phenomena—arthritic, cardiac, or nervous—may precede the others, or occur

independently of them; that is, it is not necessary that the joint-inflammation shall precede the cardiac disorder, or that the latter shall precede the chorea. A number of clinical cases are quoted illustrating the occurrence of these phenomena after preliminary sore throat. There is a species of tonsillitis which is supposed to be typical of this form of disease, and it so closely resembles diphtheritic sore throat as to be often mistaken for the latter; indeed, it probably furnishes the cases of diphtheria that are cured in three or four days. Like diphtheria also, it may be caused by sewer-gas poisoning. The following are the prominent diagnostic features of this sore throat: onset sudden, with shivering, malaise, and prostration; on the next day pretty high fever and sore throat; several spots of yellowish exudation may be found upon one swollen tonsil, and the next day the other tonsil will present a similar appearance, but is generally less severe in its course. This is a follicular exudation, and not a diphtheritic false membrane; the spots rarely become confluent, and usually clear away about the fourth day, when defervescence

is complete and convalescence begins. The grave cases may be further distinguished from diphtheria by the entire absence of enlarged glands behind the angle of the jaw. The subsequent history of the affection will confirm the diagnosis. In very mild cases the throat-symptoms may be so slight as to be overlooked by the patient. The exudation under the microscope presents the characteristic features of leucocytes, but not of true pus-cells. The devitalized cells from the inflamed tonsils are carried off by the blood, and produce local troubles in joints, heart, or brain. The multiple thrombosis of chorea may be caused entirely by these leucocytes occluding the finer vessels in the corpora striata and adjacent motor region. In this manner arterial and capillary repletion is caused, and subacute inflammation may result. Defective nutrition and impaired function follow this condition.

The relation of the cell to rheumatism is merely that of an exciting cause. A chill of the surface affects principally the capillaries of the fibrous tissues surrounding the joints, because here there is a nearly total absence of that subcutaneous fat which acts as a non-conductor of heat over the other parts of the body. The cold produces contraction of these capillaries, thus establishing a condition which favors the blocking of their calibre by the altered blood-corpuscle. Fright similarly causes contraction of the cerebral capillaries. The following is a *résumé* of the views upon the subject as presented by Dr. Stewart: 1. Follicular tonsillitis, by the process of a mild inflammation, originates the discharge of altered white blood-corpuscles, through the follicular openings on the tonsils. 2. These, or others in the tonsils not extruded, are reabsorbed into the blood by the lymphathic vessels through the glands at the angle of the

jaw. 3. By the initial inflammation, the white blood-corpuscles are deprived, to a certain extent, of their normal physiological qualities; and to the same extent as they have been devitalized they acquire pathological properties, by virtue of which they have an intensified tendency to adhere to the inner walls of the capillaries and to one another, and also to pass through the capillary walls into the connective tissues, and there form deposits. 4. They in this way become pathogenetic cells, and produce disordered nutrition and perverted functions in those organs in which they are interrupted or extruded, and thus establish the phenomena of disease. 5. These devitalized cells are revitalizable, and therefore the diseases which they produce, as a rule, terminate in recovery. He claims that this theory explains the altered blood condition observed in these affections (which is established by repeated absorption of cells or by the individual cells communicating to other cells they meet in the blood the same impress which they have already received); it accords with the apparent origin of rheumatism from damp and cold, and of chorea from fright, by according to them the power only of acting as exciting causes; it does away with the necessity of a causal connection between any members of the group; and, finally, it explains, in a rational and probable manner, the known clinical connection between, and the morbid anatomical conditions existing in, the various diseases of the group.—*Med. Times.*

**The Effect of Salicylates on the Course and Duration of Rheumatism Compared with Other Methods of Treatment, Including Results by Various Observers.**

In an able paper on this vexed question in the *Practitioner* by C. S. CLOUSTON, M. D., in which he cited a very large number of cases, he says, "When

rheumatic fever is treated by salicylates:

"1. The duration of the acute stage under treatment is reduced to three or four days, or about half its average duration under alkaline treatment; and this effect being at least as obtainable by treatment at the outset of the disease as later on, the total duration is reduced by early treatment to four or five days.

"2. The tendency to heart complication is probably less than under any other treatment; but the full value of the salicylate in reducing this risk can only be obtained by early treatment, which shortens so greatly the period of susceptibility.

"3. Convalescence is generally rapid and satisfactory, while relapses are rare if adequate precautions are taken.

"4. The best results can only be obtained by early treatment, and by rapidly saturating the system with frequent small doses (10 to 12 grains every hour) until marked benefit results and the acute symptoms disappear, after which the salicylate may be gradually discontinued, the patient being meanwhile closely watched, and the medicine at once resumed in full doses, if temperature rise or pain return."

He concludes the paper by stating that he refers to the use of salicylates in articular rheumatism with elevation of temperature; that its effects are most marked in recent acute attacks affecting the larger joints, and least so in the adynamic type of the disease so frequently seen in those who have had several previous attacks. In chronic articular rheumatism its effects are less certain. In muscular rheumatism, which is a distinct disease, I need only say in passing that the salicylate appears at times highly beneficial. Its action is, however, uncertain, and depends, I believe, in some measure on family idiosyncrasy.

#### The Treatment of Erysipelas.

In the *Wiener med. Presse*, Dr. HASTREITER recommends the treatment of erysipelas by painting with oil of turpentine, on the following grounds: 1. It can be employed on the most sensitive patients, does not require any skill, and can be applied by the patient himself as often as may be necessary, and the irritation produced by excessive friction is avoided. During its application the eyes should be protected by a pad. 2. When employed frequently enough this method is perfectly safe, and tends to produce a rapid cure. 3. Oil of turpentine can be procured everywhere. 4. All other dressings are unnecessary. 5. Internal antipyretic treatment is only rarely necessary; usually all that is necessary is to bathe the body with cold water, and to make use of cold applications to the head. 6. The inhalation of the vapor of turpentine can, perhaps, act as a preventive of the extension of the disease to the air-passages. 7. When employed at the outset of the disease it may abort the morbid process. 8. The oil of turpentine may also be employed in phlegmonous inflammation other than erysipelas.—*Med. Record*.

#### Erysipelas Propagated Throughout the Digestive Tube.

In *La France Médicale*, M. RENDU reports a unique case of erysipelas contracted through contagion, and spreading through the entire alimentary canal. The disease originated at the site of a scratched acne pimple on the left cheek.

As regards the buccal cavity, there was from the beginning no doubt as to the character of the trouble. The progressive swelling of the lips and tongue, together with the dysphagia and angina, indicated the propagation of the cutaneous dermatitis, which upon the mucous

membrane of the cheeks and lips presented identically the same characteristics as upon the skin. The next day nausea and vomiting indicated that the stomach was effected; the following day symptoms of a violent enteritis predominated, viz.: excessive tympanitis, colic, and profuse and fetid diarrhoea. This tympanitis and diarrhoea persisted, with alarming intensity, for five days, and did not begin to decrease until the end of a week. It was then that sharp pains, perineal swelling, and all the symptoms of a phlegmon appeared. In three or four days an abscess accordingly formed at the margin of the anus. Considering this in connection with the appearance later of a submental cervical abscess, the author concluded that intestinal erysipelas had existed.—*Ibid.*

#### Carbolic Acid and the Carbolates.

The following résumé of the properties and effects (physiological and otherwise) of carbolic acid and its compounds, according to the most recent works on the subject, appeared in the *Progrès Médical*, No. 46:

Crystallized carbolic acid is soluble in fifty parts of water (when chemically pure in twenty parts Binz, Hager), and in every proportion in alcohol, ether, chloroform, sulphide of carbon, glycerine.

Absorption is rapid, even through the skin when intact. Elimination is rapid by the skin, lungs and kidneys.

In the urine, when the acid has been introduced in small quantities, a phenol subphate, non-toxic, is found; when the doses have been large, another phenol compound is found (Baumann). The urine is very often of an olive-green or greenish-gray color, particularly when the acid has been absorbed through the skin or through a wound. In some cases, but rarely, albumen has been found.

*Principal physiological effects:* In the dose of from five to seven grains it has no toxic effect.

In larger doses, up to thirty grains, it induces excitation, stupefaction, vertigo, ringing in the ears, feebleness, diminution in frequency of the pulse, fall of temperature, colic and diarrhoea. In toxic doses it causes vertigo, delirium, stupor, anæsthesia, analgesia, intermittence and final arrest of heart in diastole; very rarely convulsions, collapse, coma and death. *Counter-poisons:* Succrate of lime (Huseman), sulphate of soda and the other sulphates (Bausmann), inhalations of oxygen, bleeding, transfusion (Ferrano).

The local effect produced by weak solutions is a sensation of burning, which disappears in the course of half an hour. This is the effect produced by hypodermic injection of Hueter's solution, which contains two per cent. of the pure acid; it gives rise also to ecchymosis of limited extent, but without the formation of an abscess. Hueter employs it in hypodermic injection to prevent the spread of erysipelalous inflammations to the adjoining skin; five or six injections, of twenty drops each, are made in the skin, just around the part affected, and are repeated a second time the same day; very often the spread of the inflammation is arrested.

Hypodermic injections of carbolic acid have been employed in intermittent fever, by Jessier, Declat, Hueter, Hirschberg; in prurigo, by Rezek and Fleischmann; in diphtheria, by Frotz; in phthisis, by Schnitzler; in crural neuralgia and pleuro-pneumonia, by Hayem and Kunze; in typhoid fever, by Declat; in malignant pustule, charbon, by Raimbert and Meplain (solution, 1 in 50); in nævus, by Badley; in acute articular rheumatism, by Senator, Kunze and Golbaum.—*Med. and Surg. Reporter.*

### Sub-Clavicular Tympanism.

M. J. GRANCHER concludes a very interesting communication to the Medical Society of the Hospitals upon Sub-clavicular Tympanism as follows:

Being given an acute or subacute pleurisy in a healthy man, accompanied with a medium effusion we may find out by the physical signs the part taken by the lung in the pathological process.

All clinical methods heretofore employed seek to determine the condition of the lung *behind* the effusion, that is to say at the base; none allows us to determine, what is most important as regards the distant prognosis of the pleurisy, the condition of the apex *above* the effusion.

The healthy or pathological condition of the upper lobe, may be deduced, not from such or such a sign considered alone, but from the relation of the three principal physical signs, viz., resonance, vocal vibrations, and respiration.

Three capital circumstances may be met with, and each of them corresponds to a particular condition of the apex:

1. The sub-clavicular tympanism coincides with an increase of the vocal vibrations and increased respiration.

This association of physical signs indicates that the superior lobe is healthy, that it is resonant, that it vibrates, and that it respire in a supplemental manner.

This is a particular case of a general law called the law of compensation and the schema which corresponds to it may be designated under the name of *schema or tympanism of compensation*.

2. The sub-clavicular tympanism again is accompanied with an increase of the vocal vibrations, but there exists at the same time an abnormal respiration.

This second variety of tympanism is the most common of all.

All the abnormal respirations described by authors may be observed, but by far the most frequent is *weak* respiration.

This combination of physical signs may be called *schema or tympanism of congestion*.

This congestive condition is most often, though not constantly of tubercular origin. Its true nature may be deduced from later observation of the patient, from the study of his antecedents and the functional symptoms that he presents.

3. The sub-clavicular tympanism may be encountered with a diminution of the respiratory murmur and a diminution of the vibrations.

This third combination, rarer than the preceding, answers probably to divers pathological conditions. I have found it realized up to the present with compression of the bronchi and by œdema of the lungs. That is why I call it provisionally *schema or tympanism of bronchial compression and pulmonary œdema*.—*L'Union Médical*.—*Chic. Med. Review*.

### The Causes of Malaria.

Signor TORELLI, who has recently published a map illustrating the prevalence of malaria in Italy, holds that the two principal causes of malaria are the spread of railways and the destruction of forests. Railway embankments interfere with natural drainage, and the destruction of forests causes long periods of drought, during which the earth becomes dry and porous as a sponge, so that when the rain does fall, instead of running off from the surface it is absorbed by the soil, which thereupon remains moist and gives forth noxious vapors for a long period.—*Med. Record*.

#### Disease of the Optic Disc in Connection with Typhoid Fever.

OGLESBY ("Brain," v, 2) calls attention to some of the ocular complications of typhoid fever. These changes are in the optic disc, and he has never met them in any case of typhoid fever where the patient had passed through the disease without prominent cerebral meningitis. The disc is the seat of a sub-acute neuritis, in which the effusion is of so slight a character as to deceive any but the most practised in the use of the ophthalmoscope. The visual defect is not noticed until long after the health of the patient is restored. The discs present an unusual appearance, having a peculiar tint of brownish-redness. The veins seem to carry too much blood. The contour of the disc is unaltered. As a rule, patients suffering from typhoid amblyopia have a decided appearance of facial cellular dropsy, and yet no albumin appears in the urine after repeated examinations. The disease of the optic disc grows progressively worse, and though not, as a rule, ending in atrophy, does so not infrequently. It is much more frequent among child-bearing women than among men. Oglesby has never yet met with a case in which a history of meningitis could not be obtained. In those cases in which effusion into the disc has rapidly destroyed vision, the optic tracts have presented direct evidences of softening.—*N. Y. Medical Journal*.

#### Treatment of Typhoid Fever.

Prof. KAULICH (*Jahrbuch f. Kinderheilkunde*, xvii.) has obtained excellent results in the treatment of typhoid fever by the employment of the wet pack and quinia; he believes that it is on account of this method of treatment that he has not lost a single child from the disease

under his care. In the first hours of the afternoon when the temperature is commencing to rise, he raps the child in a wet sheet, and while rubbing the child vigorously renews the cold water sufficiently often to prevent the sheet becoming warmed. Sulphate of quinia is then given in doses, varying with the nature of the case, of from fifty centigrammes to two grammes.

This mode of treatment always reduces the temperature, sometimes below normal. M. Kaulich does not believe in delaying too long the return to nourishing food, as he finds that by early feeding the duration of convalescence may be considerably shortened.—*The Med. News*.

#### Borax or Boracic Acid in Diphtheria.

At a recent meeting of the Clinical Society of London, Dr. GOODHEART narrated six cases.

In four a saturated solution of boracic acid in glycerine was used, the application being made in part by a hand-spray, in part by a laryngeal brush, and as often as every two hours in some cases. In the other two a dilute solution of the glycerinum boracis was used. The first case was a very severe one, and it died from the renal complication on the seventh day, but the boracic acid and glycerine seemed to be so successful in relieving the throat symptoms and in preventing the re-formation of membrane, that it was determined to try it again. Of the other five, three had "croup" as well as membrane on the fauces; one had nasal diphtheria; all had albuminuria. All recovered. Tracheotomy was necessary in one case, and the glycerinum boracis was freely applied to the interior of the trachea and larynx from the wound and to the surface of the wound itself, and it seemed to be very beneficial in loosening, dis-

solving and preventing the re-formation of membrane. In another case it is believed that tracheotomy would have been necessary had not the rigorous application led to the expulsion of membrane by the mouth. In all cases it seemed to, give such relief that very little difficulty was experienced in carrying out the treatment. Both borax and boracic acid have been occasionally in use as a topical application in diphtheria, doubtless for a long time past, but not, so far as is known, with any decided success; nor can it be supposed that any remedy will not often show a good proportion of failures in combating a disease such as this. It is enough to say that these agents are known to be good antiseptics, that their action is harmless when not beneficial, and that they are certainly useful in some cases.

Dr. Phillips spoke of two other cases in which glycerinum boracis had been used. It was discovered that glycerine would take up three times as much boracic acid, so that the solution could be made very strong; but this must be diluted once if used in Siegel's spray. Both the cases were in *extremis*, and died, despite tracheotomy, membrane being found post mortem in the smaller bronchi.

Dr. O'Connor had notes of about forty cases of diphtheria. He had sometimes used a saturated watery solution of boracic acid, but without special success. The most favorable results were got from a solution of chlorate of potash. He had never seen a case of diphtheria in which, on removing a piece of membrane once, there was no re-formation, though this new membrane might be thinner and more delicate looking than the first portion.

Dr. Longhurst thought that the great point was to be very careful not to irritate the parts affected. Diphtheria was

a constitutional disease, and we could not expect much from local applications. We should rather rely on the powers of nature, and see that the patient had lots of nourishment and fresh air. He considered the boracic spray to be good, because it did not irritate.

The President said that persons who adopted local applications generally extolled their own particular remedy. He could not agree with the last speaker, that local applications were of no great moment. Diphtheria was of a decidedly infectious character, and infection must take place locally, even if the disease ultimately became constitutional. As an example of the efficacy of boracic acid, which he was the first to introduce into surgery, the power it had of removing the smell of a putrid onychia was instanced. He had found out that glycerine, by the aid of heat, could be made to dissolve almost any amount of boracic acid. He had used such applications to sores of the nasal and buccal mucous membrane, with favorable results. No doubt the glycerine kept the acid longer in contact with the surface on which it was applied, and this was of great value.

Dr. Goodheart replied that the notion that diphtheria was a constitutional disease, was no argument against the use of local applications, for this local trouble was frequently enough, to cause death.

The question having been raised by the President as to what was meant by the term "constitutional," both Drs. Goodheart and Longhurst said they meant a specific poison circulating throughout the body and producing local effects.—*Med. and Surg. Reporter.*

#### Treatment of Diphtheria.

Dr. J. J. O'DEA, of Stapleton, N. Y., recommends the following, and, as he claims, successful local treatment of

diphtheria: To the entire inflamed surface surrounding the false membrane, and close up to its border, he applies, by means of a cotton-wad, the following solution: *R.* Argenti nitrat. cryst.,  $\mathfrak{Dj}$ .; spt. æther. nit. dulc.,  $\mathfrak{z}$  iv.; aquæ destill.,  $\mathfrak{z}$  iv., *M.* In the same manner he then makes an application of the following mixture to the surface of the false membrane, and out to its extreme edge, but no farther: *R.* Acid. carbol., gr. viij.; liq. ferri subsulph.,  $\mathfrak{z}$  ijss.; acid. sulphurosi.,  $\mathfrak{z}$  ijss.; glycerinæ,  $\mathfrak{z}$  j. *M.*

These are to be repeated twice, or possibly three times in twenty-four hours, the second mixture to be supplemented by a gargle of lime-water, thus allaying irritation and removing the debris of false membrane broken down by the action of the acid. When nothing remains of the deposit save some milky white patches he omits the applications and employs only the lime-water gargle of spray.

#### Diphtheria.

Dr. Goss, in *South. Practitioner*, gives the following as his treatment: As this is a highly septic disease, the treatment, both local and constitutional, must be actively antiseptic. Seeing quite a number of essays upon this disease, in various journals, positively asserting that the muriated tincture of iron, quinine and muriatic acid, or chlorate of potash would readily cure this most formidable disease in all its various stages, and under its several types, and having seen a great many failures in the use of these remedies, and having seen the success attending a treatment based upon the pathology of the disease, I am induced to give my experience in the treatment of the graver types of this destructive enemy. I admit that iron, quinine, also muriatic acid, or chlorate

of potash may cure some cases of the mildest form of this disease, but are utterly powerless in the graver types; this I have witnessed time and time again, in various epidemics. In cases that take on rather a typhoid condition, bleeding of the nose, sordes upon the lips, gums and teeth; putrid odor of mouth, with great prostration; the internal use of muriatic acid, and the local application of the tincture of eucalyptus globulus, alternated with a saturated solution of the permanganate potassium, used every one or two hours, will be found to give success. When the exudate is grayish-white, with great prostration, then the internal use of salicylic acid, 5 grs. every three hours, and the tincture of eucalyptus, and the solution of the permanganate of potash applied as above, will be followed by success. In cases where there is a very great tendency to decomposition of tissue, and the discharge from the mouth and nose is very acid, then the iodide of arsenic, given in small doses, say 1-30 or 1-40 of a grain, every three hours, will have a salutary effect, and the permanganate solution, say a 20 per cent. solution, may be used by the atomizer. But in the malignant form, the cyanide of mercury is the remedy, given in doses of 1-25 to 1-30 of a grain, every three hours, and the above local applications used, either with the pencil brush, or with a good atomizer. In many cases that I have recently treated, of the grave types, I gave 5 to 6 grs. baptisia, *wild indigo*, alternated with the iodide of arsenic, with fine success. In these cases I used the eucalyptus and the saturated solution of the permanganate of potassium locally. In cases where the gums and tongue are swollen and very sore, the biniodide of mercury is also a valuable remedy, in doses of 1-30 to 1-40 of a grain, well diluted with water, as it is irritating to the stomach. The 1-100

solution of bromine, given in doses from 1 to 3 gtt. every quarter of an hour, has had fine effect in some epidemics in Europe. And if a saucer with aqua bromine, renewed every 10 or 12 hours, is set in the patient's room, it will have a good effect on the disease. The patient should also, in all the grave forms of the disease, breathe the vapor of chloride of calcium; and in many cases, 10 to 15 grs. of the liq. calcis chlor., taken in half a glass of water, will have a good effect. Where there is a very offensive odor about the breath of the patient, a solution of carbolic acid may be used with a good atomizer, say 3 to 4 grs. to the ounce of water. The sulphide of calcium is also an antiseptic of much value. The local applications of alcohol, in which sulphur has been dissolved, *ad saturandum*, will have a fine effect; it may be applied with a pencil brush, three or four times in the twenty-four hours. The alcohol is not only antiseptic, but has been found to kill all forms of *parasitic fungi* or *bacteria*, especially *micrococcus diphtheriticus*, hence as a local application, it is anti-diphtheritic, and so is sulphur, especially, when thus dissolved in alcohol.

#### DISEASES OF THE NERVOUS SYSTEM.

##### Differential Diagnosis between Hysterical Paralysis and Polio-myelitis Anterior.

Dr. A. HUGHES BENNETT, (*Lancet*.)

1. Judging from the history, symptoms and progress of the case, in a large number of instances, it is difficult or impossible to diagnose between paralysis from hysteria and from polio-myelitis; 2. A correct differentiation between them is of the highest importance, as the treatment successful in the one is useless or may be injurious in the other; 3. In order to arrive at a true diagnosis we

must as far as possible apply physical agents in their investigation; 4. In the diseases under consideration the conditions of the reflexes, resulting from physical manipulations, afford us valuable information, although open to certain exceptions; 5. Electricity supplies us with an agent which, in the large majority of cases, will definitely enable us to correctly decide whether a given paralysis is due to organic disease of the anterior cornua of the cord or to that affection to which we apply the term hysteria.

##### The Latest Sphæro-Bacterium.

The *Chicago Medical Journal and Examiner* publishes the following:

DRS. DANIEL R. BROWER and LESTER CURTIS were in attendance upon a lad affected with perfectly typical tetanus, resulting from a wound in his hand inflicted by the explosion of a toy pistol. They determined to examine his blood with the microscope, and, having done this, discovered that it was swarming with organisms precisely similar to the sphæro-bacteria recognized in the ill-conditioned pus removed from an abscess communicating with a joint. The blood of a horse affected with tetanus was then placed by them under the same objectives, and in it also similar organisms were discovered. Not content with pushing their investigations to this point, they proceeded to examine the mother of the boy who was their patient, and also another of her children; and, to their surprise, found in the blood of each an abundance of the same germs. A neighboring frog-pond was finally searched, and found to furnish masses of the same bacteria. The boy recovered from his tetanus, and was taken before a body of scientific gentlemen in this city, where his blood, still swarming with bacteria, was placed on slides and

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examined by a dozen or more physicians and others of unquestioned discrimination and veracity. All were able to recognize the existence of the bodies to which their attention was directed.—*Med. Record.*

### Tetanus from Slight Causes.

Two cases of fatal tetanus, induced by slight injuries, are reported in the *Maryland Medical Journal*. The first case is related by Dr. H. J. BERKELEY. The patient, a strong healthy man, forty years of age, was vaccinated in January, 1882. A few days later, after exposure to cold, the arm became swollen and inflamed. Three weeks after the vaccination had been performed symptoms of tetanus appeared and continued to increase in severity for several days, until death ensued. The second case, reported by Dr. R. B. Davy, was that of a woman suffering from a uterine polypus. Dilatation of the os was effected by means of laminaria tents, and the new-growth was removed by the curette. Four days later the patient experienced some uneasy sensations about the throat, tetanus set in, and death resulted within one week after the insertion of the tents.—*Ibid.*

### The Therapeutic Action of Zinc.

Dr. TESTA (*Dublin Journal Medical Science*) draws the following conclusions from experiments made with a twenty per cent. solution of sulphate of zinc injected hypodermically: 1. Zinc possesses a marked action on the heart; it diminishes the force of cardiac contraction and reduces blood-pressure. It then causes an increase in blood-pressure by direct action on the blood vessels, causing their contraction. 2. Zinc acts on the intra-cardiac termination of the pneumogastric nerve; and, 3,

causes arrest of the heart in diastole. 4. It diminishes peripheral sensibility up to complete anæsthesia, and causes motor paralysis. 5. Zinc reduces the excitability of the nervous system, and is indicated in convulsive neuropathies; it also reduces utero-ovarian hyperæmia, and is indicated in hysteria. 6. It is also indicated in nervous palpitations.—*Ibid.*

### The Cause of Sick Headache.

The fact long known to the profession that errors in visual refraction may cause sick headache, is now being widely circulated again. Hypermetropia and astigmatism are the things that most often have to be corrected.—*Med. News.*

### Borax in Epilepsy.

Dr. STEWART LOCKIE reports in the *British Medical Journal*, the case of a boy of seventeen who had been subject to epileptic seizures for four years. At the time of admission to hospital they occurred about once a week. Bromide of potassium seemed to have some slight controlling influence at first, but the frequency soon reappeared. On November 28th, 1881, borax in fifteen grain doses three times daily, was substituted for the bromide, and it has been continued, with an intermission of nine days, during which the bromide was renewed, to this date (October 21, 1882). From the time it was commenced no serious fit has occurred, and for the last six months he has had no seizure whatsoever. No skin eruption occurred; vomiting took place occasionally, if the medicine was taken before meals, and at one period he complained of sleeplessness.—*Med. and Surg. Reporter.*

### Atropine in the Treatment of Epilepsy.

Dr. DAVID advises the treatment of epilepsy by the simultaneous employ-

ment of atropine and the bromides of potassium and ammonium. For a period of six months he orders twenty grains of the bromide of ammonium—thrice daily. At the same time the patient is instructed to take a granule of one milligramme of sulphate of atropine morning and evening. At the end of six months the following pills are prescribed: Valerianate of zinc, 4 centigr.; extract of belladonna, 6 milligr.; arsenious acid, 2 milligr.; extract of gentian, q. s.

Two of these pills are taken daily during twelve months. Should the faintest symptom of the threatened occurrence of the epilepsy appear the treatment must be kept up for yet another twelve months.—*Lyon Medical*.—*N. Y. Medical Journal*.

#### Nerve-Stretching.

MM. DURET and BONNAIRE contribute a paper to *Le Progrès Médical* bearing upon the history and the results of nerve-stretching. They contend that the results of the operation have been fairly satisfactory. Elongation of the nerves impairs their sensory but not their motor functions, producing a greater or less degree of anæsthesia according to the force employed. The operation produces marked pathological changes in the *vasa vasorum*; the vessels of the stretched nerves become dilated and sinuous, even the capillaries participating in this change. Eight or ten days after the operation, embryonic connective tissue and newly formed vessels are found in the nerve trunks. Capillary hemorrhages may result from the elongation, but while the medullary layer and axis cylinder are sometimes divided, the sheath of Schwann remains unbroken. Certain degenerative changes subsequently occur. The degenerated fibres are usually situated in the periphery of the nerve trunks, and extend

from the point of traction almost to the roots of the nerves concerned. In the cases studied by the authors, the degeneration consisted, during the first few days, in the disappearance of the myeline and of the axis cylinder in many of the fibres. Later it was characterized by hyperplasia and hypertrophy of the fibres and by proliferation of the nuclei in the inter-annular segments. Lesions in the cord and the medulla may follow nerve-stretching. M. Duval observed ecchymoses and congestion of the medulla after elongation of the *par vagum*. Considerable force may be applied to a large nervous trunk without rupturing it, but it is not admissible to employ more than fifteen kilogrammes (thirty-two pounds), even in elongating the sciatic or the median.—*Med. Record*.

#### Bromide of Uranium In Tabes.

DR. A. VULPIAN (*Revue de Médecine*), claims that in certain epileptiform phenomena occurring during locomotor ataxia he has found the bromide of uranium at times of service. He gives it in one sixty-sixth grain doses three or four times a day. In certain cases it is not borne well, but where it is it has a marked action on both the epileptiform phenomena and the pains of locomotor ataxia.—*Chic. Med. Rev.*

#### Allyl Sulphide in Rabies.

Dr. DUJARDIN-BEAUMETZ claims that the Russian treatment of rabies is one which yields very good results. The patient is placed in an over heated room and sulphide of allyl administered. Three persons who had been bitten by a dog, undoubtedly rabietic, were submitted to this treatment by Dr. Beaumetz, and none have displayed any evidence of the disease, although six months have elapsed since they were

bitten. It cannot be said that such results are any evidence that the treatment is of value, since it is by no means sure that these three patients would have become rabietic, had they been allowed to remain untreated.—*Ibid.*

## DISEASES OF RESPIRATORY ORGANS.

### Antiseptics in Phthisis.

Dr. WM. PORTER, Physician to Throat and Lung Department, St. Luke's Hospital, St. Louis, thus summarizes:

Proven, it seems to me, are these two propositions:

1. Phthisis is a specific disease from a specific cause.

2. Phthisis may be produced by absorption of tuberculous matter in contact with the mucous membrane of the air passages or intestinal tract.

There is also evidence that the energy of this tuberculous matter is due to germ development and progression.

Hence the value of antiseptic influence in the treatment of phthisis, not only in the later stages during pus production and absorption, but also in the earlier process of infection.

One great demand is for that, which by local and internal use, may meet and destroy the septic agencies of disease. Such a remedy must be effective, unirritating and non-poisonous, susceptible of ready dilution and easy absorption, and withal inoffensive in odor and taste.

Carbolic acid and iodoform do not fully meet these requirements, and less harmful though less potent means of antagonizing contagion and putrefaction are finding favor.

The compound known as Listerine has for nearly two years served me better than any other remedy of its class, and, in the treatment of phthisis, has almost supplanted in my practice all

other antiseptics. In treatment of diseases of the upper air passages it is pleasant and does not irritate; in the fermentative dyspepsia so often accompanying phthisis it is safe and efficient.

It is the most powerful non-toxic antiseptic I have yet found.—*Cincin. Lancet and Clinic.*

### Tincture of *Carduus Marianus* in Hæmoptysis.

Dr. LESENEVITCH has employed the tincture of *carduus marianus* (milk thistle) in five cases of hæmoptysis. The dose is fifteen to twenty drops in a teaspoonful of water every two hours. In three of his cases, in which there was consolidation at the apices, the blood in the sputa was greatly diminished in quantity after six doses, and had entirely disappeared at the end of two days. Digitalis, the mineral acids, and ergot had previously been tried without success. In two other cases, in which cavities existed, no improvement followed the administration of the drug for three days, while ergot subsequently given arrested the hemorrhage in thirty-six hours.—*Journal de Médecine de Paris.—Med. Record.*

### Olive Oil in Chest Disease.

Dr. W. THORNTON PARKER, (*Med. Times*): While a student in the private clinic of Prof. Von Giëtt, at the General Hospital in Munich, 1873, I learned from him the value of sweet oil (*oleum olivæ*) in all forms of chest trouble, acute and chronic. Olive oil is undoubtedly superior to all other preparations for inunction.

Prof. Von Giëtt uses olive oil in the following manner: The patient's chest is first thoroughly bathed in the olive oil, slightly warmed; then a strip of clean, old and soft shirting, large enough to envelop completely the whole chest, and

saturated with the oil, is carefully adjusted. Another piece of dry cloth covers the first: over this can be placed cotton batting or flannel, but usually only the clothing of the patient. This is the only application made by Prof. Von Gielt in diseases of the chest where *warmth* is indicated. The old-fashioned and dangerous Indian-meal jacket he strongly condemns. These inunctions of olive oil will be found excellent in all cases where artificial nutrition is sought for. This method of treatment is especially advisable in bronchitis, pleurisy, pneumonia, and pulmonary consumption.

#### Local Treatment of Pulmonary Cavities.

In appropriate cases of cavities in the lung tissue, due to inflammatory processes, and limited to a small region of the organ, the remainder being sound, LOKOŁOWSKI has made use of direct injections into the cavities of a solution of carbol-iodine in the strength of 1-20 per cent. Injections of carbolic acid solutions were always followed by temporary increase of temperature. The results obtained were not satisfactory, as the local as well as the general condition did not seem to be improved.—*Centralblatt f. Chir.—St. Louis Cour. of Med.*

#### Specific for Sore Throat.

After a large number of observations, Dr. ROBT. N. HORMAZDI, of Cheltenham, has come to the conclusion, that in all acute cases of *tonsillitis* salicylate of sodium is a specific, while in chronic cases it seems to possess no effect whatever. He recommends about 15 grains of the remedy every hour, till the most urgent symptoms are relieved, when only half the dose is administered. At the same time he employs a gargle, consisting of about 10 grains of the salicylate of sodium, one ounce of glycerine and three ounces of water. He found the

remedy especially specific in its effect in very acute and severe cases, as also in the angina of scarlatina, and of erysipelas.—*Med. and Surg. Reporter.*

#### Catarrhal Conditions—Insufflation of Medicated Powders.

According to Dr. D. H. GOODWILLIE, New York, the following powders have been found most useful:

*Number 1.*—℞. Benzoicæ, ʒ j.; morphinæ mur., gr. vi.; bismuthi subnitrat.; potassi nitrat., āā ʒ ss.

Valuable for its sedative action. To be used in hyperæmic conditions, with pain. In the beginning of an attack of rhinitis coat the mucous surface with it.

*Number 2.*—℞. Aluminis, ʒ j.; acaciæ; bismuthi subnitrat.; potassii nitrat., āā ʒ iv.

Useful where a strong astringent is indicated. In case of hæmorrhage from the nose, remove all the clot and immediately blow in this powder abundantly until the bleeding ceases.

*Number 3.*—℞. Iodoformi; camphoræ, āā ʒ j.; bismuthi subnitrat.; potassii nitrat., āā ʒ jss..

A good antiseptic. To be used where the discharges are fetid, or where ulceration is present, or an excessive amount of granulations. The camphor masks the odor of the iodoform. These powders, when impalpable, and with the therapeutic integrity of these drugs preserved, can be more effectually applied to the nasal passage than spray, and their good effect is certainly more prolonged. For the general practitioner they are vastly more convenient than sprays.—*Arch. Med.—The Southern Clinic.*

#### On the Use of Carbonate of Ammonia Sachets for Bronchitis.

M. MELSSENS having observed the good effects of the atmosphere of a stable on those suffering from pulmonary

diseases, which are rightly attributed to the emanations of carbonate of ammonia, he thought that continued, yet moderate, respiration of this salt might be useful in other affections of the respiratory organs. After a serious attack of bronchitis, he decided on trying on himself the effects of carrying a little bag around his neck containing little pieces of carbonate of ammonia. From the first day the amelioration was felt, and the cough soon disappeared entirely, while often persons who suffered from chronic bronchitis also obtained relief. The use of little bags of carbonate of ammonia are intended to produce the same result as the air of a stable or a gas works.—*Med. Press.*

#### DISEASES OF DIGESTIVE ORGANS.

##### Turpentine for *Tænia Solium*.

In the *Southern Clinic*, Dr. H. L. HARRIS relates the case of a mulatto girl to whom he gave on Thursday afternoon—*R.* Ol. terebinthinæ, ʒ ss.; ol. ricini, ʒ iss. *M.* Sig. Tablespoonful at a dose, and directed that one dose be taken, and that the patient retire fasting, and await development until 1 o'clock Friday.

At 12.20 o'clock, Friday, he was summoned, and found she had passed a monster tapeworm, measuring seventeen and a half feet in length, careful measurement. She suffered from soreness over the hepatic region, but the abdomen has fallen, and the patient feels well.—*Med. and Surg. Reporter.*

##### *Tænia Solium*.

Dr. SELL presented two specimens before the New York Pathological Society (*Med. Record*). One was obtained from a female patient, thirty years of age, single, who had been aware of the

presence of the worm for three years. The other was obtained from a female patient, thirty years of age, married, who had been aware of the presence of the worm for three months.

The plan of treatment was somewhat different from that which he had reported at a former meeting, and was as follows: Ten grains of calomel were given on a Friday evening. On Saturday the patients took nothing into the stomach except stewed pumpkin and slippery-elm tea. On Sunday they took the following mixture, divided into four equal portions, and administered at intervals of fifteen minutes: *R.* Pumpkin seeds, ʒ j.; ethereal extract of male fern, ʒ j.; kameelæ, ʒ ij. *M.*

If the patient does not have a free evacuation from the bowels within two hours after taking the last dose, or as soon as gurgling, with or without colicky pain, appears, administer an ounce of Rochelle salts, or Epsom salts, or, in cold weather, castor oil. When purgation begins, have the patient sit over a pail partly filled with warm water.

To prepare the medicine, remove the outer envelope of one ounce of fresh pumpkin seeds, and then beat them into a paste with one hundred grains of sugar finely powdered. To this paste add half a fluid ounce or more of water, and when a homogeneous mixture has been obtained add the other ingredients gradually, and to the whole add water sufficient to make four ounces.

##### Constipation.

When constipation is due to torpor of the muscular layer of the intestine, combined with defective secretion of the mucous membrane, Dr. BARTHOLOW uses either of these formulæ: *R.* Tr. nucis vomicæ; tr. belladonnæ; tr. physostigmæ aa. f. ʒ ij. *M.* Sig. Thirty drops in water, morning and evening.

Or, R. Ex. physostigmæ; ex. belladonnæ; ex. nucis vomicæ, aa. gr. v. M. Et. ft. in. pil. No. x. Sig. One pill at bedtime.—*Medical Gazette.*

#### Cascara as a Laxative.

Dr. CARTER, of Liverpool, in an article on new therapeutic agents, writes to the following effect concerning cascara (*rhamnus purshiana*): The fluid extract prepared from the bark of this shrub, or small tree, is an excellent remedy in chronic constipation. I have used it now for two years, and have no doubt of its value. The fluid extract is reddish brown in color, and extremely bitter. A very good method of prescribing it is in a mixture, with twice its quantity of glycerine, or one of the flavored syrups. Of this a fluidrachm should be given three times a day, and the dose be diminished as soon as its aperient action is developed. It is what may be termed a tonic aperient, and seems to produce an effect somewhat like that caused by belladonna and nux vomica united with an ordinary aperient. It evacuates the whole canal. The motion is not watery, but usually semi-solid, truly feculent in character, and voided without difficulty, and so far from causing subsequent constipation, the bowels will often act regularly after its use has been entirely discontinued. I have used it so extensively, and the testimony to its value is so unmistakable, that it would be difficult to select particular cases to prove this.—*Med. Record.*

#### Hot Water in Nausea and Vomiting.

Dr. MORTON says, in the *Louisville Medical News*, that several years ago he learned from his own personal experience that no agent relieves nausea and vomiting so satisfactorily and promptly as water, as hot as can be drank. Since then he has used it in a large number of

cases, and no remedy he ever administered in any condition has proved more uniformly reliable. He has preserved records of many of these cases, and makes the following classifications: 1, cases in which nausea and vomiting occurred at the onset or during the course of acute febrile disease; 2, cases in which these symptoms were caused by overloading the stomach when its functions had been impaired by protracted disease; 3, cases in which they were produced by nauseous medicines (not emetics) at the time they were taken; 4, cases of acute gastritis caused by the ingestion of irritants; 5, cases in which these symptoms were purely reflex; 6, cases of chronic gastritis; 7, cases of colic in newly-born infants; 8, cases of flatulent distention of the stomach in adults.—*Ibid.*

#### Injections of Hot Water in Dysentery.

Dr. JOHN G. EARISH gives, in the *College and Clinical Record*, the history of three cases of dysentery, in all of which copious injections of hot water resulted in almost instantaneous amelioration of all the distressing symptoms, followed by a speedy cure.—*Ibid.*

#### Maggots in Fæces.

A correspondent writes to the *British Medical Journal* that he was called upon to attend a boy, aged ten, who had been out of sorts for some time. He was pale, anæmic, and had a foul breath. He finally passed a scybalous mass of fæces swarming with maggots. A quantity of butter in use in the house was found to contain maggots, and this, no doubt, was the origin.—*Med. and Surg. Reporter.*

#### Digestibility of Cooked Milk.

One of the results obtained in a series of experiments by M. HOFFMANN

on the digestibility of casein was that with artificial gastric juice the cooked milk yielded a greater quantity of peptone than fresh milk.—*Centrablatt für Med. Wissenschaft.*—*N. Y. Med. Jour.*

## DISEASES OF THE URINARY ORGANS.

### Meigs on Bright's Disease.

Dr. ARTHUR V. MEIGS, of Philadelphia, gives some excellent clinical observations on albuminuria, based upon a study of sixty-two cases seen in private practice. The following is a summary of it:

There has been much said of later years about kidney disease without the presence of tube-casts in the urine, and of the presence of casts without albumen. I may say that I have frequently found tube-casts in the urine when the most careful chemical examination failed to detect any albumen, and *vice versa*, have failed to find any casts at all, when the event proved the existence of renal diseases.

The subject of treatment I have not even mentioned in my paper, although much might be said about it, because I have already trespassed too long upon your time.

In conclusion, I will briefly recapitulate the points which it has been my endeavor in this paper to prove.

1. That in no ordinary, uncomplicated case of Bright's disease should a prognosis of speedy death, or even of incurable disease be given, for I have related cases in which the disease was chronic, lasting more than two years, and which ended in complete recovery, and others in which the person affected has lived nine years.

2. That dyspnoea, usually taking the form of renal asthma, is much more common than is usually supposed, and

when properly appreciated, is a valuable diagnostic sign of the disease; also, that severe coryza is a complication or accompaniment, and has a diagnostic value.

3. That Bright's disease, as a cause of death, is on the increase.

4. That it is a very common cause of the deaths of old people, probably being the direct cause in many deaths reported as of old age.

5. That the passage of gravel, even when microscopic in size, but particularly if large enough to cause nephritic colic, is a prolific cause of the disease.

6. That the occurrence of tube-casts in the urine, without, or in advance of, the presence of albumen, is very common, and *vice versa*, persons may die of Bright's disease, and the most careful examination fail to show any tube-casts, although there may be albumen constantly present in the urine.

7. That the abuse of alcohol is certainly a cause of kidney disease, as proved by the case I have related, in which it has, again and again, caused hemorrhage from the kidney, with the temporary presence of albumen and tube-casts in the urine, disappearing again with the cessation of its consumption.—*South. Pract.*

### Pilocarpine in Polyuria.

A patient suffering from polyuria azotica used belladonna, bromide of potassium, laudanum, injection of morphine, and electricity without effect. Hypodermic injections of nitrate of pilocarpine, 0.20 in water 20.0, diminished the daily secreted urine from ten litres to two litres, and the quantity of urea was reduced from nine grammes to three grammes. The weight of the body increased to eight kilogrammes in two months' time. In polyuria glycosurica the sugar disappeared after a short time. Fifteen injections will generally cure these diseases.—*H. Morgagni Giornale.*—*Ibid.*

## CONSTITUTIONAL DISEASES.

### The Treatment of Acute Rheumatism.

Dr. ROBERT BARTHOLOW (*Medical Record*): No one can give anything like attentive consideration to the types of rheumatic cases without perceiving that they may be resolved into three groups, as regards the characteristics of the individuals composing them:

1. Spare persons of considerable bodily vigor, good muscular development, and having a distinct family history of neurotic or rheumatismal disorders.
2. Obese subjects, addicted to malt liquors and good living, sometimes with—more often without—an inherited predisposition to rheumatic diseases: the gelatinous descendants of albuminous parents, as they have been entitled.
3. The feeble, pale, anæmic subject, depressed by poor diet and evil hygienic surroundings, including dampness and bad air.

No one can treat cases of rheumatism successfully unless he recognizes the type before him and adapts his remedies accordingly.

The first type is comparatively frequent and found amongst the best elements of our mongrel population. Besides the inherited tendency, such subjects are prone to indulge in a rich diet of animal food, sauces and wines, and to pursue rather sedentary occupations, or an indoor life. In these cases, salicylic acid, or the salicylate of soda, renders an incontestible service. There are, however, some practical details regarding its administration of great moment in respect to the permanency of the results. It is quite certain that in this group of rheumatic cases, full medicinal doses of salicylic acid, or of the salicylates, will speedily arrest the pain and diminish

the fever. The lowering of the temperature seems to bear a constant ratio to the diminution of the pain. It is not possible to express in figures with exactitude the doses necessary; the curative effect is attained by that quantity which reduces the pain and the temperature. In suitable cases, the administration of this remedy removes all of the more prominent symptoms and establishes convalescence in three or four days. Unfortunately, in a considerable proportion of cases, the disease manifests a strong tendency to relapse, after a marked subsidence of the acute symptoms which apparently indicates the beginning of convalescence. A rule of practice has been distinctly formulated since this tendency to relapses has become well known. It is this: Give the remedy for several days after the acute symptoms have ceased. I have attempted, from my own experience, to give numerical expression to this rule, with the following result:

Salicylic acid, or the salicylates, should be given after the subsidence of the acute symptoms, and the cessation of the fever and pain, for the same number of days as the acute attack lasted. Thus, if the decline of fever and pain occurred on the fourth day, the remedy should be continued as many days thereafter, or for four days subsequent to the apparent cessation of the acute symptoms.

The second class of rheumatic subjects contains the obese, or those of full habit, the rotund addicted to malt liquors and to good living, all of whom are apt to suffer from a form of acid indigestion. The cases of rheumatism occurring in such subjects are, as a rule, much benefited by the alkaline treatment. This method is an empirical attempt to cure a disease characterized by an excess of acid in the various secretions. Dr. Fuller, the author of an excellent work on rheumatism, has been

the most prominent advocate of the alkaline method.

"By the 'alkaline treatment,'" says Dr. Fuller, "I mean a plan of treatment in which alkalies play an important part, but which consists not only in the administration of alkalies, but in the careful regulation of the secretions, the strictest attention to diet, and the administration of tonics, such as quinine and bark, as soon as the patient can bear them. \* \* \* My practice is to give not less than an ounce and a half of the alkaline carbonates, either alone or in combination with a vegetable acid, during the first twenty-four hours of treatment. \* \* \* More commonly two drachms are ordered to be taken in effervescence every three or four hours in combination with an ounce of lemon-juice, or with half a drachm of citric acid dissolved in four ounces of water. At the same time, if the bowels are torpid, ten grains of colocynth and calomel pill [British Pharm.] are prescribed at bedtime. As soon as the urine, when freshly voided, ceases to show an acid reaction—which is usually the case after twenty-four hours—the quantity of the alkali is diminished by one-half, six drachms only being administered during the succeeding twenty-four hours. At the expiration of that time, if the urine remains alkaline, three drachms only are given in the next twenty-four hours; and on the fourth day, if the urine still shows an alkaline reaction, the form of the medicine is altogether changed. The treatment ceases to be essentially alkaline; either a cinchona draught is ordered to be taken three times a day, containing a scruple or a half drachm of bicarbonate of potash—a little more or a little less according to the condition of the urine, which should be kept nearly neutral—or three grains of quinine dissolved in lemon-juice is given three

times a day in effervescence, with half a drachm of bicarbonate of potash or soda. \* \* \* The diet is restricted to beef-tea or broth, with soda-water and milk, and barley-water as a drink, as the smallest quantity of solid food, given a day before the tongue has thoroughly cleaned, is apt to induce a recrudescence of the disease. Wine and spirits are strictly forbidden, though experience has convinced me that wine and spirits prove less hurtful than the smallest quantity of solid food."

If the relation between the action of alkalies and the neurotic disturbance called rheumatism, be demanded, we are not without resources for an explanation. Pflüger's phenomena of electrotonus were long ago explained by Matteucci, and the explanation confirmed by Becquerel on the ground of the chemical action developed by the passage of the current. Humboldt was the first to show that the excitability of a nerve is increased by contact with an alkaline solution, and diminished by contact with an acid solution. Now, as the condition called rheumatism may signify a depressed state of the trophic functions, the good effects of alkalies are at once apparent—that is, the increase of the functional activity—and thus counteract the depression.

The third type of rheumatic cases, and numerically the most important; probably, also, pathologically, the most serious, is the feeble and anæmic subject. A rheumatic of this kind is pale, rather thin, the muscles weak and wanting in firmness, the chest narrow and somewhat flat, the joints prominent and lax. In such persons an extension of the rheumatic inflammation from joint to joint, until almost all the joints of the body are involved, is to be feared, as it is of frequent occurrence. Cardiac complications are relatively frequent. It

need hardly be observed that in such subjects the depressing effects of salicylic acid and of the alkalies are to be dreaded. Here clinical experience is in entire accord with theory. We owe to Dr. Russell Reynolds, of London, the introduction of a remedy for acute rheumatism, which is especially suited to this group of cases. I refer to the *tincture of the chloride of iron*. To be effective it must be given in full doses—from ʒ ss. to ʒ j. in sufficient water every four to eight hours. It lessens the swelling and pain of the joints, lowers the fever, diminishes the tendency to heart complication, and, above all, sustains the vital powers in their struggle against the encroachments of the rheumatic disease.

I am far from denying that cases of rheumatic fever in these anæmic subjects would not be relieved by salicylic acid, but I do affirm that so much depression would result that relapses would occur, and the convalescence would be prolonged owing to the remarkable depression of the nutritive functions. The same state of things results from the administration of alkalies. The blood is despoiled, the heart enfeebled, and complications of various kinds invited. On the other hand, very conspicuous benefit results from the vigorous administration of the tincture of iron. Besides its influence over the course of the disease—shortening its duration by checking waste, and preventing complications by maintaining the vital resources—the tincture of iron, as shown by the late Dr. Anstie, has a distinct prophylactic effect, so that, when an attack is threatened, it will, by timely administration, prevent it.

During the period of convalescence from acute rheumatism, after the treatment by salicylic acid and by alkalies, the tincture of iron in the full doses al-

ready advised renders an important service. The tenderness and effusion about the affected joints, the subfebrile temperature, and the condition of anæmia, are alike greatly improved by its administration in efficient doses. I have repeatedly observed that cases which lingered long on the hands of the physician after the acute symptoms had subsided, quickly improved and recovered when efficient doses of the tincture of iron were administered, and, at the same time, suitable blisters were applied to, or about, the affected joints.

Independently of the considerations above expressed regarding the utility of blisters, the "blister treatment" of acute rheumatism is deserving of careful consideration. Blisters in various ways, and applied in accordance with various notions, have long been used in the treatment; but the "blister treatment," properly speaking, of acute rheumatism has been systematized by Dr. Davies, of the London Hospital, and Dr. Dechilly, of France. The latter, however, applied a large blister to cover the joint, and permitted it to remain on until sufficient inflammation occurred to produce abundant serosity. Dr. Davies, on the other hand, was content to apply the blisters around rather than on the joint itself. It is a remarkable fact that blistering brings about a neutral or alkaline condition of the urine, how acid so ever it may have been before the blisters were applied. More or less strangury occurs in some instances. So remarkable is the relief to pain produced by the blisters that patients petition for their renewal from time to time. Cardiac complications are comparatively infrequent, and the duration of the disease is reduced to the limits of the favorable cases. Indeed, I may sum up the testimony as to the efficiency of this method in the words of Dr. Greenhow, who af-

firms that the treatment of rheumatism by blisters is quite as successful and less objectionable than by salicylates.

The good effects of the blister treatment afford a strong justification of the neurotic theory. When first ascertained, the result was ascribed to the withdrawal of a quantity of acid serum from the neighborhood of the affected joints. The change in the character of the urine, induced by successive blisters, rendered further explanation necessary. The increase of our knowledge respecting the influence of peripheral irritation on the state of the nerve-centres, and especially on the trophic system, has paved the way to a better appreciation of the facts; nevertheless the final explanation remains to be made.

A combination of the blister treatment with salicylic acid, with alkalies, or with the tincture of iron, may often be made with signal advantage.

The importance of a proper diet is not less than is stated by Dr. Fuller in the quotation made from his paper. Solid food should not be allowed in any case. Liquids composed of starchy and saccharine matters are only less hurtful. Milk and animal broths are the articles to be depended on chiefly until the cessation of all joint troubles will permit the gradual restoration of a solid dietary. Lemonade and carbonic acid water are allowable, unless they produce flatulence, when they will excite fresh joint mischief. Anodynes are to be avoided if possible; when necessary, atropine is preferable to morphine, if adequate to relieve the pain, which it usually succeeds in doing. The complications which may arise in the course of rheumatic fever demand more careful treatment than I can give them at the conclusion of this article.

#### Fasting in Acute Rheumatism.

Dr. WOOD, Professor of Chemistry in the Medical Department of Bishop's College, Montreal, reports in the *Canada Medical Record* a number of cases in which acute articular rheumatism was cured by fasting, usually from four to eight days. In no case was it necessary to fast more than ten days. Less positive results were obtained in cases of chronic rheumatism. The patients were allowed to drink freely of cold water, or lemonade in moderate quantities, if they preferred. No medicines were given. Dr. Wood says that from the quick and almost invariably good results obtained by simple abstinence from food in more than forty cases in his own practice he is inclined to believe that rheumatism is, after all, only a phase of indigestion, to be cured by giving complete rest to all the viscera.

#### Rheumatism, Acute and Chronic.

R. Guarana, grs. xv. With hot water, cream and sugar for a dose, and increase to forty grains once or twice a day. Said to be almost a specific in acute rheumatism.—*Southern Practitioner*.

#### Tha Cyanides in Acute Rheumatism.

Dr. A. LUTON gives the cyanide of zinc in pill, in doses of from three-fourths to one and a half grains in a single day.

The cyanide of potassium, pure and well prepared, is perhaps to be preferred, he thinks, to the salt of zinc, on account of its evident activity. In mixture he gives it in the dose of one and a half grains per day. It is best administered in the form of pills, coated with silver. It is not advisable to go beyond two grains a day.—*Independent Practitioner*.

**Local Application of Salicylate of Soda in Acute Rheumatism.**

In the *British Medical Journal*, Dr. CHARLES ORTON alludes "to a severe case of polyarthritis acuta in a young lady aged 19, where joint after joint became red, swollen and exquisitely painful and tender." He tried "many local applications, besides internal remedies, without giving much relief," until he "applied lint soaked in a solution of salicylate of soda, under a cover of oiled silk, to the affected joints. The relief was speedy and great." He has since tried it in a few cases in private practice with success, and is now using it more extensively in cases under his care in the North Staffordshire Infirmary.—*From the Ephemeris of Mat. Med. Phar., Therap., etc.*

**Oil of Wintergreen in Rheumatism.**

Dr. KINNICUT has been experimenting with the oil of gaultheria in rheumatism, and publishes his results in the *Medical Record*. The oil of gaultheria, or wintergreen, contains ninety per cent. of the methyl ether of salicylic acid. It mixes in all proportions with alcohol and ether, and is soluble in water. In twelve carefully recorded cases the results obtained were similar to those obtained by salicylic acid. Therefore Dr. Kinnicut concludes: that the oil of wintergreen is an efficient salicylate in the treatment of acute rheumatism; that in its efficiency in controlling the pyrexia, the joint pains, and the disease, it at least ranks with any of the salicylic compounds; that it is best given in repeated doses, which should be diminished in quantity and in frequency as convalescence progresses; that it is less disagreeable to the taste, and is not attended with the occasional toxic effects which are produced by the acid or its sodium

salt. This drug is eliminated rapidly, and the dose therefore should be repeated every few hours. In the cases recorded from ten to twenty minims were given every two hours. Dr. Kinnicut's experience may prove of decided value, especially with children, and again in places where the salicylates, as ordinarily used, are not to be had.—*Chic. Med. Review.*

**Colchicin in Muscular Rheumatism.**

The following clinical note is reported by Dr. A. B. HIRSH, (*Med. Times*):

J. H., German, aged 28, brewer, was admitted into the German Hospital on the 28th of August, 1882, as a case of muscular rheumatism. The history showed this to have been the first attack, due to exposure to wet and cold, and contracted two months before. During this time he had not had any regular medical attendance, but had vainly used many popular nostrums for relief. Upon admission, the patient was robust and well nourished; he had no fever, but there was great tenderness and pain in the muscles involved, which were chiefly those of the calves of the legs and the flanks on both sides. Following the hospital custom in these cases he was at once placed on salicylate of sodium for a few days; but, no relief being experienced, he was ordered twenty drop doses of tinct. ferri chlor. in one drachm of syr. limon., four times daily, given well diluted with water. He was kept in bed, and locally a combination of chloroform, turpentine, and soap liniment was directed to be used night and morning. A week later it was found necessary, for the acute exacerbations of pain, that a quarter of a grain of morphia sulph. be injected beneath the skin occasionally. It should be stated that while confined to his bed his diet was carefully regulated, meat and stimulants being

interdicted. This plan was continued until September 18, with the result of affording temporary relief, but without permanent success. Indeed, the patient was often in greater pain than at any time previously. The attending physician now resolved to use colchicum, and, in order to avoid its action upon the alimentary canal and to test its powers locally, it was decided to give it hypodermically. For this purpose the imported alkaloid was employed. Five minims of a one-tenth per cent. solution of Merck's colchicin was now ordered to be injected into the painful muscles as required, never more frequently than three times, but at least once, daily. To this was subsequently added a warm bath every night just before retiring, the liniment before mentioned being used once a day. Marked improvement was soon apparent, so that the patient himself remarked his comparative comfort and freedom from pain following the injections, a mere soreness remaining in the parts. Signs of incipient inflammation about the seat of one or two of the punctures were quick to disappear upon application of a solution of lead-water and laudanum.

The improvement was manifest from the start, and the patient rested well during this night for the first time since his attack began, and it continued in spite of a spell of continuous damp and chilly weather lasting several days; for, although it brought a slight return of the old symptoms, they were by no means so severe, and were easily controlled by the daily injections, in which there was no intermission. September 25 was again cloudy, and he complained of some soreness in the lumbar muscles. The pain had increased in the right side, because of which a deep injection was made on this day into the latter region, giving speedy relief. Now,

although next day's weather was just as unfavorable, the muscular pains were entirely absent. Some remaining tenderness in the region of the sacrum was controlled by a belladonna plaster. Symptoms continuing favorable, he was discharged, cured, on October 6, having been free from pain for more than a week. He was instructed to return to the dispensary if he had more pains, but up to this date (November 8, 1882) he had not again sought relief.

#### Venesection in Acute Rheumatism.

Dr. DUNCOMBE (*Canada Lancet*), reports a case of acute rheumatism, which did not yield to salicylate of soda, bicarbonate of potash, nor colchicum. The attack lasted several months and the temperature and pulse remained high. As a last resort, a pint of blood was taken from the patient and he began to improve almost immediately. In two days he was able to walk with crutches, and in two days more his temperature and pulse became normal. From that time forward recovery was rapid.—*Chic. Med. Review*.

#### Chorea and Rheumatism.

At the last meeting of the British Medical Association (*British Medical Journal*), Mr. E. RICKARDS read a paper before the Section of Medicine. He claimed that chorea is a functional disease of the brain. From his observations, he believes that chorea occurs exclusively in individuals of an excitable nervous temperament, and at a time of life when the mind is least stable, and that it may frequently arise solely from fright. He thinks that chorea is caused by mental disturbances because the movements are under the control of the will and cease during sleep. He thinks that the casual relationship between rheumatism and

chorea must, at present, be purely speculative. He states that in no instance has he seen valvulitis develop in a choretic patient unconnected with rheumatism, and that valvular disease of the heart is associated with chorea only through rheumatism.—*Ibid.*

#### Insanity Cured by Erysipelas.

DR. FRITSCH (*Jahrbücher für Psychiatrie*), reports two apparent cases of melancholia, which recovered after being attacked by a delirium resulting from erysipelas. The first patient had markedly depressing delusions but no hallucinations. The second patient had both hallucinations of hearing voices through a telephone and depressing delusions. The second case seemed to have systematized hallucinations, and although Fritsch says she was cured, she continued to be "nervous." It is probable that this was a case of monomania, and the supposed recovery a remission due to the erysipelas. He also reports a case of progressive paresis, which was markedly improved by erysipelas. Fritsch's cases, though quite interesting, are not exceptional, as similar ones have been reported by Esquirol, Sponholz, Nasse, and Macleod. That acute febrile disturbances sometimes exert a favorable influence on insanity has long been known.—*Med. Record.*

#### Curative Action of Erysipelas.

According to Dr. DAUCHEZ (*L'Union Médicale*), erysipelas may exert a beneficial effect upon a number of diseased tissues by exciting in them a healthy action through active inflammation. It modifies favorably some ulcers, especially phagedenic chancre and lupus. Fungous tumors are destroyed, old suppurations dried up, and elephantiasis cured. This action is indeed rare, yet

it is sometimes observed, and the possibility of its occurrence should be borne in mind.—*Ibid.*

#### The Physical Signs of Pleuritic Effusion.

Dr. R. DOUGLAS POWELL concludes a lecture on the physical conditions produced by pleuritic effusion as follows:

1. That until the pleura (previously under healthy conditions) is about two-thirds full of fluid, no positive pressure is exercised upon lungs or heart.
2. Up to this point, therefore, there is no tendency for the fluid to escape on puncturing the chest unless air be allowed to replace it. Its removal, otherwise, can only be effected by aspiratory or siphon power.
3. It is only in effusions beyond this point, therefore, that the diaphragm becomes depressed.
4. On the other hand, the heart is necessarily displaced from the very commencement of the effusion, and in proportion to its extent; cardiac displacement being thus a valuable index of effusion, but no measure of intrathoracic pressure.—*Medical Times and Gazette.*

#### Jaborandi in the Treatment of Pleurisy.

Dr. DUFOUR relates the case of a child, six years of age, suffering from double pleurisy, in which excellent results were obtained from the use of jaborandi. Several blisters had been applied without result, and at the end of two weeks the symptoms were so serious that it was feared that the effusion would become purulent. One drachm of jaborandi was ordered to be given in infusion. The half of this amount had hardly been taken when the child broke out into a profuse perspiration, but without ptyalism. Dr. Dufour believes that pilocarpine always

causes salivation, while jaborandi produces sweating alone. On the day after the administration of the drug the effusion had disappeared, and respiration was normal. The patient went on to a good recovery.—*Journal de Médecine de Paris*.

#### Leucæmia and Pseudo-Leucæmia.

SENATOR contends that the only difference between leucæmia and pseudo-leucæmia is one of degree, according to the greater or less proportion of white corpuscles in the blood. The change from one form to the other is not uncommon. In cases of chronic anæmia, with enlarged spleen, in which the number of white corpuscles is about normal, the diagnosis is pseudo-leucæmia (splenic anæmia.) When, under the same conditions, the white corpuscles are increased in number, the disease is leucæmia. Senator states that leucæmia is as common in children as in adults. The question as to whether heredity or unfavorable surroundings can be regarded as etiological factors, the author is unable to decide. He denies any dependence of leucæmia upon rickets, otherwise, he says, since rachitis is so common a disease, leucæmia and pseudo-leucæmia should be met with much more frequently than is the case.—*Deutsche Medicinal-Zeitung*.

#### Hereditary and Congenital Malaria.

In an article on this subject in the *Revue de Médecine*, No. 7, 1882, Dr. CHARLES LEROUX concludes as follows: "Owing to a lack of sufficiently numerous and definite observations it is impossible as yet to affirm the existence of congenital malaria, or to determine the role played by heredity in the etiology of infantile malaria. The fact, however, of congenital hypertrophy of the spleen, accompanied by certain

characteristic lesions of malarial cachexia in the infants of women suffering from intermittent fever, would seem to point to a congenital or hereditary malaria. Some children appear to have at birth an hereditary predisposition to malarial fever, even when not exposed to any causes from without. They are often seized, shortly after birth, with a remittent fever of the same type as that displayed by the mother." The author leaves unsettled also the question whether the theory of heredity is able to explain the intermittent character of certain infantile affections, and the effect upon them of anti-periodic medication.—*Med. Record*.

#### Chinolinum Tartrate.

Dr. CARL ROSNER (*Prakt. Arzt*.) writes: Chinolinum, a constituent of coal-tar as well as the Dippel's tar, was introduced into medicine as a substitute for quinine a short time ago. The tartrate is the only preparation adapted for internal use. It is found in silk-like shining crystals. If at the start it must be conceded that quinine will not be displaced by the new preparation, it deserves, nevertheless, some attention and further trial on account of its antiseptic and antisedative effects, and the more so as the price of this article is five times less than quinine. The tartrate of chinolinum is used in single doses of from five to fifteen grains. The daily maximum dose for an adult at present is placed at 3 ss. Children of five to ten years receive the third part of the adult dose. Rosner has ceased to use this remedy in practice of children, however, on account of its nauseous and disagreeable taste. On the other hand, in adults he recommends emphatically chinolinum in febrile diseases, and has obtained excellent results in the treatment of pulmo-

nary phthisis. The formula which he employs is as follows:  $\mathcal{R}$  Chinolin tartrat, gr. 45; ext. cinchon. gr. 135 M. ft. pil. No. xx. D. S.—Two pills every two or three hours (thus 0.3 (gr. v.) per dose). Under some circumstances, as in phthisis, an addition of opium (0.005 per pill) can be recommended. A good way of administering the pill is in a boiled prune.

#### Burnt Alum in Ague.

BABOO BROJENDRA NATH BANERJEE (*London Practitioner*), states that this is a very cheap, easily procurable, and efficient anti-periodic medicine. The value of alum is chiefly marked in cases of fever in which the attacks come on with clockwork regularity. It usually fails in irregular types of intermittent fever. Two doses are generally sufficient to complete the cure. Eight grains of burnt alum are to be given in each dose. The first dose is to be given three hours, and the next an hour before the expected attack of fever.—*Ibid.*

#### Chronic Malarial Hæmaturia.

Prof. ORENDORF recommends the use of strychnia under the skin in this disease. This drug, he says, stands at the head of the vasomotor stimulants, and is especially useful in low vascular tension. It should be administered in full doses that the relaxed vessels may be made so tense as to prevent exudation. By full doses is meant the amount required to produce the desired effect: which is to stop leakage. Therefore, if one-thirtieth of a grain does not suffice, push it to one-twentieth, to one-fifteenth, and then to one-tenth, repeating sufficiently often to secure and keep secured the physiological action of the drug.—*Chic. Med. Review.*

#### Considerations on the Origin and Natural History of Tuberculosis.

DR. THOMAS E. SATTERTHWAITE, in an interesting article on this subject, published in the *Medical Record*, comes to the following conclusions:

1. Tuberculosis is a disease that deserves the name hereditary, for it attaches itself to certain families throughout many successive generations; and it is most apt to attack those members that are deficient in physical vigor, from whatever cause. Proper precautions often enable those that are thus liable, to escape it or withstand it successfully.

2. The most distinguishing characteristic of tubercle is the occurrence, in the tissues, of minute, bright, glistening, translucent particles that have been called miliary tubercles, granula, granulations, etc.

3. They are the result of an inflammatory process, because they can be produced by the introduction of mechanical irritants into the system.

4. When these minute bodies coalesce to form larger bodies and undergo a change of color, they are known as crude or yellow tubercles.

5. Some of them contain the reticulated tissue that has been called adenoid, because it resembles the retiform tissue of lymphatic glands. As the miliary tubercle advances in age, one or more large multi-nuclear foci may be found, either at the centre or periphery of the nodule. Sometimes Schneppl's epithelioid corpuscles are found, sometimes lymphoid elements, and sometimes fibrous tissue, but no one of these tissue elements, which all belong to the connective-tissue series, is pathognomonic of tubercle.

6. The lungs and serous membranes are most frequently attacked, and it is here that the natural history of the

tubercle is studied to the best advantage. In other regions of the body there may be modifications of the tubercle, so that its distinctive character is difficult to demonstrate.

7. In the gradual development of these bodies they undergo caseous change at the centre, which phenomenon is another marked feature of tubercle. Still, in some instances we have reason to suppose that the miliary tubercle may become organized, and thus a cure result.

8. Tubercles are rarely found without more or less contiguous inflammation that may be classed as a pneumonia or bronchitis. The latter is the *infiltrated tubercle* of Laennec, the *catarrhal pneumonia* of Niemeyer, or the *desquamative pneumonia* of Buhl. The pneumonia may, perhaps, be protective in some instances, serving to wall off a caseous process, thus preventing it from becoming disseminated, or it may eventually itself participate in the same process and lead the way to necrosis of the lung and the production of cavities.

9. Tubercles may be confined to a limited area and a single lobe of the lung, or a single lung, or they may be diffused pretty equally in different organs. Generalized, disseminated, or secondary tuberculosis is the most dangerous and malignant, and is probably due to transmission of the disease by the lymphatics or blood-vessels, usually the latter. In this secondary form the first manifestations are the gray granulations, as they are also in the primary form.

10. Tuberculosis is inoculable, producing its kind if it produces anything, but other substances will also, in a certain number of cases, produce the same apparent lesions; in fact, not only any organic substance that is capable of

physical deterioration, but also a variety of non-organic substances.

11. There is some good evidence favoring the theory that consumption is contagious, *i. e.*, that it is capable of propagation by *cohabitation*, or, in other words, close association with persons that have the disease. The number of well-authenticated instances in the human being, where the origin of the disease can be explained in this way, is sufficient to give considerable strength to the theory. The best evidence on this point is obtained from a study of phthisis in the domestic animals, especially in horned cattle.

12. And yet the morphological differences between their form of phthisis and those of the human being are such as to put us on our guard against forming hasty conclusions from a comparison between them.

13. Nor does it appear that we have good grounds for believing that the meat or milk of phthisical cattle, when taken as food, has ever produced a single instance of tuberculosis in the human being.

14. But we should, none the less, discountenance the sale of such meat or milk, since even if they are not infectious, they are deficient in proper nutritive elements, and for this reason alone should be debarred from sale.

15. And so in the case of bovine virus, though it does not appear that any person has been rendered tuberculous, yet no vaccine virus should be held to be suitable for vaccination purposes unless proper assurances have been given that the animals yielding the vaccine were in every respect free from tubercle, as determined by inspection after slaughtering.

16. Pulmonary tuberculosis and pulmonary phthisis are, in the majority of cases, interchangeable terms.

17. As a natural deduction from the above views attention should be directed chiefly, in prophylaxis and treatment, to the vicious constitution which is conceded to be an essential prerequisite of the disease, rather than to a contagion that at best plays only a comparatively infrequent and subordinate role.

## DISEASES OF THE NERVOUS SYSTEM.

### Remedies for Headache.

The following recipes and suggestions for the treatment of different forms of headache are collected from a variety of trustworthy sources :

Two grains citrate of caffeine, in capsule, taken every half-hour, is a very effectual remedy in nervous and sick headache. One or two doses are often sufficient to give complete relief. The only objection to its use is sleeplessness, which sometimes results if it is taken in the evening. It is preferable to guarana as being hardly ever rejected by the stomach.

The following, according to Dr. W. W. Carpenter, is very effectual in most forms of headache : Muriate of ammonia, 3 drachms ; acetate of morphia, 1 grain ; citrate of caffeine, 30 grains ; aromatic spirits of ammonia, 1 drachm ; elixir of guarana, 4 ounces ; rose water, 4 ounces. Mix. Dessert spoonful every ten or twelve minutes.

In nervous headache, Dr. W. A. Hammond states the value of various drugs as follows :

Oxide of zinc is of great value. Ordinary dose, 2 grains, three times a day, after meals ; maximum dose, 5 grains. It is best given in form of pills.

Nux vomica is preferable to strychnia. The dose is 1-4 grain, after meals. If the patient be chlorotic, it is well to

combine a grain of reduced iron and half a grain of sulphate of quinine.

Bismuth, in the form of subcarbonate, will often take the place of oxide of zinc. Dose, 2 grains, after each meal, Bismuth probably aids digestion more than any mineral tonic, and is of use when there is gastric disturbance.

The bromides are serviceable when the nervous system has been irritated ; when it is exhausted they do harm.

Phosphorus is very useful in most forms of nervous headache. The best results are obtained from dilute phosphoric acid, in doses of 30 drops, largely diluted, three times a day, after eating, or phosphide of zinc, 1-10 grain, in pill, three times a day.

Arsenic, as a nerve tonic, stands next in value to zinc. Dose, 5 drops of Fowler's solution three times a day, after meals.

Galvanism is sometimes valuable, but by no means a specific. The *constant current* should always be used, being careful to avoid too great intensity, lest amaurosis be produced.

Dr. T. Lauder Brunton, editor of the London *Practitioner*, says ; The administration of a brisk purgative, or small doses of Epsom salts, three times a day, is a most effectual remedy for frontal headache when associated with constipation ; but if the bowels be regular, the morbid process on which it depends seems to be checked, and the headache removed even more effectually, by nitro-muriatic acid, diluted 10 drops in a wine-glass of water, or bicarb. soda, 10 grains, in water, before meals. If the headache be immediately above the eyebrows, the acid is best ; but if it be a little higher up, just where the hair begins, the soda appears to be the most effectual. At the same time the headache is removed, the feeling of sleepiness and weariness, which frequently

leads the patients to complain that they rise up more tired than they lie down generally disappears.

A writer to the London *Lancet* remarks: At the Middlesex Hospital female patients who have suffered many years from sick headache, evidently of a hereditary character, have been greatly benefited, if not cured, by the administration of 10 minim doses of tincture of Indian hemp, three times daily before the attacks. This is well worthy of trial in those cases of ever-living, never-dying martyrdom-like suffering.

In headache due to determination of blood to the head and in fever, the following simple treatment is to be commended:

Put a handful of salt into a quart of water, add an ounce of spirits of harts-horn and half an ounce of spirits of camphor. Cork the bottle tightly, to prevent the escape of the spirit. Soak a piece of soft cloth with the mixture and apply it to the head; wet the rag fresh as soon as it gets heated.

Soaking the feet in very warm water, in which a spoonful of mustard has been stirred is also beneficial in drawing the blood from the head. Two teal spoonfuls of powdered charcoal well stirred in a half a glass of water and drank at once, is a valuable remedy in sick headache from sour stomach, flatulence, etc.

Tincture of *nux vomica* is recommended by Ringer as possessed of real curative powers, when given in drop doses, repeated every 5 or 10 minutes, for 8 or 10 doses, and then continued at longer intervals, for sick headache, accompanied with acute gastric catarrh, whether due to error in diet, constipation, or no apparent cause.—*Hos. Gazette*.

#### Hystero-Epilepsy in a Boy.

M. BOURNEVILLE has put on record, in the *Progrès Medical*, a second case of hystero-epilepsy in a boy. The child was 13 years of age when he came under observation. The following points in his history seem worthy of note. His parents were first cousins. His father was subject to migraine in early life; his mother had spasmodic wry neck in infancy; one of her sisters was idiotic (?). The patient was the eldest child. He seems to have been always an excitable child and easily frightened, subject to night terrors. His hysterical attacks commenced in the month of February, 1880, about a month before he came under observation. The first one came on whilst he was at work at school, with vertigo, and, after lasting two hours, was terminated by singing, crying and laughter. The senses of hearing, sight, taste, and smell were decidedly less acute on the left than on the right side, and the same may be said of the common sensibility of his buccal mucous membrane and conjunctiva. His intellectual faculties seemed unimpaired, and he was said to be gentle and affectionate. There was no history of masturbation. On examination, several different areas were found, over which pressure was painful (*zones hystérogènes*). They were situated as follows: 1, "*clou hystérique*," at a small spot, two centimetres in front of the vertex; 2, "*rachialgie*," over the spinous processes of the fifth, sixth and seventh dorsal vertebrae; 3, symmetrical spots on each side in the fifth intercostal space, midway between the nipple and the axillary line; 4, a painful spot in the seventh left intercostal space, about five centimetres from the spine; 5, a spot over the manubrium sterni; 6, symmetrical spots over the loins; 7, a spot almost over the centre of

the iliac fossæ, corresponding to the "ovarian" region. That on the left side is the most marked. The attacks recurred at regular intervals, and lasted from one to two hours. They were preceded by an aura, which consisted of a sensation of a ball rising from the penis to the epigastrium, and thence to the level of the larynx. This was followed by the "*clou hystérique*," and then he lost consciousness. The attacks were characterized by a preliminary stage of rigidity of unusually short duration, succeeded by a clonic-period, which was, on the other hand, of unusual length, comprising varied contortions and passionate attitudes. During this period he would try, by different methods, to injure himself or those around him. The attack concluded, he sometimes had hallucinations of sight. He also presented a hemi-anæsthesia, at one time on the left side, at another on the right. The patient was cured (apparently in a permanent manner) by the assiduous use of cold douche-baths. The case may be noted as a typical one, both of hysteropilepsy and of the way in which the physician's office is magnified in such disorders by French *confrères*.—*Med. Times and Gazette*.

#### Muscarin.

HÜGYES has made experiments upon animals with muscarin and has arrived at the following results: 1. Muscarin increases the excitability of striped muscle-fibre. 2. It depresses very rapidly the functional activity of the central nervous system, and lessens the excitability of the peripheral nerves. 3. The dilatation of the blood-vessels after an injection of muscarin is an immediate result of the paralytic action of this poison on the vaso-motor centre. Later, there ensues a depression of the activity of smooth muscle.—*Du Bois-Reymond's Archiv*.

### DISEASES OF THE URINARY ORGANS.

#### Sudden Death and Coma in Diabetes.

FRERICHS distinguishes three forms of sudden death, or coma in diabetes: 1. Sudden death from syncope, collapse, paralysis of the heart after exertion, etc. 2. Coma, ushered in by gastric or other local affections, and accompanied by headache, delirium, anxiety and dyspnoea. 3. Coma without dyspnoea, commencing with headache, vertigo, a feeling of intoxication, and drowsiness. As regards the alleged causes of coma and sudden death in diabetes, Frerichs states: (1) Edema, or anæmia of the brain must be rejected on the evidence furnished by numberless autopsies. So also must (2) the existence of hyperglycæmia, an inspissation of the blood, whereby the corpuscles are changed and rendered unfit for the respiratory function. (3) Uræmia can be proved to exist neither through examination of the urine nor by any changes found post-mortem in the kidneys. (4) Fatty emboli have been discovered in the capillaries of the brain or lungs in only a very insignificant number of autopsies. (5) Acetonæmia. Large quantities of acetone have been found in the urine of diabetic and other patients in whom no nervous disturbances were present. Further, large doses of acetone, administered to men and animals, have failed to produce any dyspnoea or brain symptoms. The theory of necrotic processes in the kidneys, advanced by Ebstein, the author, also rejects, as other observers have failed to substantiate his discoveries. The so-called hyaline changes in the urinary tubules, however, are constant. This hyaline substance, Frerichs asserts, is produced by glycogenic degeneration—is, in fact, glycogen. Analogous changes have been found in the liver, the heart,

inflamed lung tissues, and other organs.  
—*Weiner Med. Wochenschr.*, No. 35,  
1882.—*Med Record*.

#### The Prognosis of Diabetes.

From a consideration of six hundred cases of diabetes, which have come under his personal observation, Dr. SCHMITZ, of Neuenahr, feels justified in formulating the following conclusions: Prognosis depends upon, 1, the earliness of the discovery and treatment of diabetes; 2, the strictness with which the anti-diabetic regimen is observed; 3, the etiological factors; 4, the age of the patient; 5, the degree of immunity the patient enjoys when he chances to use sugar-breeding food. In early cases the prognosis is favorable. Diabetes depending on central nervous lesions or on grave chronic affections is serious: depending on worry, pain and grief, or on over-use of sugary food, it is less so. Gouty diabetes has the best prognosis of all. After the age of thirty the prognosis grows steadily worse. It is bad if sugar persists on an exclusive diet of fish and flesh. It is decidedly favorable if eggs, salad and mild cheese can be taken without breeding sugar, which only reappears when fruits, starchy roots, starch or cane-sugar are taken.—*Wiener Med. Wochenschr.*, No. 11, 1882.—*Ibid*.

#### An Explanation of the Uræmic Seizure.

Dr. RÜHLE (*Transactions of the German Medical Congress*, 1882) states that in every case of death from uræmic convulsions œdema of the brain is found to exist. But simple œdema of the brain does not cause convulsions, and some toxic agent must be added to the serous exudation to produce this condition. That chemical changes accompany the uræmic attacks is shown by the fact that

the gastric secretions become alkaline, and that the breath turns moistened litmus-paper blue. So soon, therefore, as œdema of the brain comes on in the course of these, as yet undefined blood charges, it acts as a poison and gives rise to convulsions.—*N. Y. Med. Journal*.

#### Diabetes.

Dr. HUGO EUGEL, in the *Phil. Med. Times*, outlines a treatment of true diabetes advanced by Dr. Theodor Clemens, of Frankfort-on-the-Main, and which has met with constant success at the hands of the Carlsbad specialists. The treatment consists in attention to the dietary, the exhibition of liquor brom-arsen and the application of electricity.

The liquor brom-arsen is a solution, in glycerine and water, of the arsenite of bromine, such that two drops of the solution represent the twenty-fourth of a grain of arsenite of bromine. It is not contended that it will cure any case in the last stages, although great benefit has been derived from its use even at advanced periods of the disease. The dose is from one to four drops or more, in a wine-glassful of water, three times a day and immediately after a meal, which should consist largely of meat. The dose must be increased gradually till a decided impression is made upon the percentage of sugar in the urine. It is maintained at this until its effect is lost, and then the dose is increased, and this process continued until the sugar entirely disappears.

The thirst and diuresis is quickly lessened, and at the same time the percentage of sugar is decreased. Diabetics can take large doses continuously without deleterious effects.

Sugar is frequently overlooked, even

when sought for, and this on account of decomposition. Dr. Clemens uses a few drops of a solution of thymol 2.0, alcohol 30.0 to preserve the urine. This has no effect upon the reduction and polarisation tests for sugar.

In regard to the diet, Clemens follows Schiff's views, and distinguishes between the liver and brain diabetics. In the former, the percentage is uninfluenced by the presence of hydrocarbons in the diet; in the latter it is favorably acted upon. The diminution of the chlorides in the urine is looked upon as a grave prognostic—in fact pointing to a near and fatal termination.

Inhalation of oxygen developed by electricity is an useful adjuvant; and still more efficacious was found the transmission of sparks and shocks of static electricity through the liver and other parts of the body.—*Canadian Practitioner*.

#### **Causes of Transitory Albuminuria.**

FISCHL.—It is a well-known fact from the publications of Ultzmann, Edlefsen, Furbringer and others, that a temporary albuminuria has been observed in perfectly healthy individuals. In these cases it was possible to trace the cause to anemia, great muscular exertion, depressing mental emotions, etc. Fischl adds another variety of cases, in which, likewise, no organic lesion of the kidneys exist. He relates the clinical history of ten cases treated for the following disorders: cordialgia, gastralgia (due in one case to ulcer, in another to carcinoma of the stomach), colic, enteralgia, hepatic colic—in short, abruptly developed, painful affections of the abdominal organs, which are accompanied by manifestations of shock of more or less severity (pallor, muscular weakness, threadlike pulse, etc.). During the period

of the attack the quantity of urine secreted was considerably diminished, the specific gravity high and albumen present in quantity. The albumen gradually disappears after the abatement of the attack and its threatening symptoms, to return, however, upon the reappearance of the paroxysms. The cause of this transitory albuminuria F. refers to the shock, which is common to all these various attacks. In consequence thereof the blood-pressure becomes lowered, the arteries contract and stagnation of blood occurs by preference in the large veins of the abdominal organs. Hence, there takes place in the kidneys a venous stasis accompanied by arterial anæmia, and very low blood pressure. This is the very condition which, according to the theory of Runeberg, is requisite to affect a transudation of albumen from the malpighian glomeruli. With the recovery from shock and re-establishment of the renal circulation the transudation of albumen ceases. Fischl, therefore, regards albumen in these cases as a symptom of shock, which view is substantiated by the fact that in cases in which the collapse is not called forth by painful paroxysms, albumen may also be detected in the urine. Thus F. relates cases in which after great loss of blood (metrorrhagia and hæmateuresis) and severe diarrhœa albuminuria was a manifest symptom.—*St. Petersburg Med. Woch.—Med. Rec.*

#### **The Intestinal Origin of Certain Alkaloids Found in the Urine.**

In a previous paper read before the Société de Biologie, Dr. BOUCHAT announced the discovery by him of certain alkaloids in the urine during the course of infectious diseases, and expressed the opinion that they were vegetable alkaloids originating from the in-

fectious agents rather than any product of the animal cells. At that time he had found none in normal urine. Since then, however, he had succeeded in determining their presence in the urine in health, but believes that they are elaborated in the alimentary canal by vegetable organisms, the agents of intestinal decomposition. Those diseases as typhoid fever, which increase intestinal putrefaction, augment proportionately the quantity of alkaloids in the urine; and in proportion as this process is controlled by charcoal or other agents, the alkaloids in the urine are diminished. Hence he concludes that they are generally found in the intestine (though possibly also in the tissues), are absorbed in part by the mucous membrane, and excreted by the kidneys.—*Revue de Médecine.—Med. Record.*

#### Action of Pepsin.

*The London Med. Record* reports a case of retention of urine due to the presence of coagulated albuminoid masses in the bladder. All the symptoms were relieved by the injection of pepsin, which dissolved the masses—*Chic. Med. Review.*

### DISEASES OF RESPIRATORY ORGANS

#### Turpeth Mineral and Calomel in Laryngitis.

DR. A. W. ROGERS, (*Med. and Surg. Reporter*): There are many things worthy of remembrance which daily occur to us as practitioners, which we do not communicate to the journals because we suppose they may not be sufficiently new or remarkable; but which nevertheless may be instructive to many readers.

In your issue of November 11th, I notice two articles in regard to the use

of two important remedies, in both of which I have had corroborative experience. One relates to the use of Turpeth mineral in laryngitis. I have used this medicine in croup for near forty years, and consider it one of the most reliable remedies in that disease. It is the most prompt emetic I know of, and has the effect of producing a speedy and large secretion and expectoration of mucus, which often at once arrests the disease. If given early in attack, it is often all that is needed. If given later, it is often successful. But it is not to be relied on alone in cases where the disease is confirmed. In this case emetics can only occasionally be given—once in 3 or 4 or 5 hours. The strength must be husbanded, nutriment must be carefully administered and allowed to continue on the stomach. And now a slower process of relieving the congested lining of the larynx and trachea and separating the plastic exudation must be relied on. Above all the means which I have seen used, calomel is the most reliable—given with a minute portion of ipecac in doses of from a half to one grain every hour or so. A very little soda bicarb. may also be added to the powders. In addition to the above, the patient should constantly inhale warm vapor. The steam generator should be in constant operation at the side of the bed, and the head so hooded as to keep the vapor over the nose and mouth. With these means, Turpeth mineral, calomel and steam, and keeping up the patient's strength by nutriment and sometimes stimulants, I have saved a number who I think would otherwise have perished. Some have recovered after a week of anxious care. Of course the effect of the remedy on the mouth, bowels, etc., needs watching.

# CONSTITUTIONAL DISEASES.

## Observations on the Management of Enteric Fever, according to a Plan based upon the so-called Specific Treatment.

JAMES C. WILSON, M. D. (*Med. and Surg. Reporter*):

So soon as the patient is found to have enteric fever, or in many instances so soon as his symptoms warrant a reasonable suspicion that he is about to develop it, he is put to bed, ordered a diet consisting of milk, animal broths, jelly and simple custards, in small amounts and at intervals of two or three hours. At night he is given a dose of calomel. This dose varies in amount from  $7\frac{1}{2}$  to 10 grains (0.5 to 0.66 grammes) and is repeated every second evening until three or rarely four doses have been administered in the course of the first six or eight days. It is given alone or in connection with sodium bicarbonate. There is commonly a slight increase of diarrhœa, if it be present, without aggravation of the other symptoms, and in some instances the tendency of the temperature at this time to steadily rise, appears to be controlled. If, as is frequently the case, spontaneous diarrhœa has not recurred in the first week, the calomel usually brings about two or three large evacuations on the day following its administration, not more. In either case the tendency to frequent passages in the later stages of the attack, is favorably influenced by the repeated administration of this drug during the first week. If the case does not come under observation until after the tenth day, one only, or at most two doses of calomel are given. No further doses of it are, however, given during the course of the attack unless constipation occur. In this event, if the evidences of extensive or deep implication of the intestinal

wall, such as abdominal pain, tenderness or marked tympany are absent, calomel in  $7\frac{1}{2}$  grain (0.5 gramme) doses is given at intervals of three or four days. If there is reason to suspect serious intestinal lesions, the lower bowel may be more safely emptied of its contents every third or fourth day, by enemas of moderate size (8 to 10 fluid oz.) It is necessary to bear in mind that the gravest lesions of the gut, leading even to hæmorrhage and perforation, have occasionally been observed in cases characterized, not only by constipation, but also by an entire absence of pain or tenderness and very moderate tympany. The danger of salivation from calomel, in these doses in enteric fever appears to be slight. In only one case in sixteen were the mercurial fetor and slight swelling of the gums observed.

Excessive diarrhœa has been controlled by the use of opium, either in suppositories, containing 1 gr. (0.06 gramme), or by the mouth in quarter grain (0.016 gramme) doses, often associated with bismuth and given *pro re nata*. It is an invariable rule that the patient be kept in the horizontal position, and to the use of the bed-pan and urinal, from the time of the recognition of the disease until the defervescence is completed. He is, however, turned upon his side from time to time, and made to maintain that position for twenty or thirty minutes, if necessary, being supported by the nurse.

From the beginning of the attack, the following mixture is readily administered in doses of one, two, or even three drops in a sherry-glassful of ice-water, after food, every two or three hours during the day and night:  $\mathcal{R}$  Tinct. iodinii, f. 3 ij. (8.00 c. c.); acid carbolic liq., f. 3 j. (4.00 c. c.) M.

Unless some unusual circumstances occur to render a change necessary, this medicine is not suspended until the at-

tack draws to a close. It is well borne by the stomach, and excites no repugnance on the part of patients. In one case only has it been necessary to omit the carbolic acid on account of the disgust assumed by its odor.

Partly for the sake of its favorable influence upon the skin, and for the sake of cleanliness, partly because of its favorable though slight influence upon the temperature, the patient is to be sponged twice a day with equal parts of aromatic vinegar or alcohol, and cold water. If it is more grateful to him this sponging may be done with tepid water, the evaporation of an extensive film of water not below the temperature of his body probably being not wholly without a refrigerating tendency.

When the evening axillary temperature reaches  $104^{\circ}$  F. ( $40^{\circ}$  C.), quinine in massive doses, 24 to 30 grains (1.66 to 2.00 grammes), is given upon a falling temperature. I usually direct 8 to 10 grains to be given in solution at 5, at 5:30, and at 6 A.M. the following morning. Administered thus at the decline of the temperature in its diurnal revolution, these large doses of quinine depress it from  $2.5^{\circ}$  to  $3.5^{\circ}$  F. ( $1.4^{\circ}$  to  $1.8^{\circ}$  C.) After the lapse of forty-eight to seventy-two hours, if necessary, the dose may be repeated. If these doses be rejected by the stomach—an usual circumstance—half the quantity of quinine may be administered hypodermically. For this purpose a citric acid solution is to be preferred. Since the adoption of the plan of treatment under consideration, I have not encountered cases attended with such hyperpyrexia as has rendered attempts to control it by cold baths necessary or even advisable.

The minor nervous symptoms are best held in check by skilful nursing. For the relief of the headache of the first ten days absolute quietude, a dim light, etc.,

are often sufficient; occasionally the bromides alone or in combination with chloral are required. Later in the course of the disease chloral is unsafe.

Alcohol is not often indicated prior to the beginning of the third week. It may, however, by reason of the habits of certain patients, be necessary throughout the attack.

The considerations which led me to adopt the plan of treatment indicated in the foregoing sketch, are :

I. A feeling of dissatisfaction regarding the expectant method of treating enteric fever. This feeling, vague at first, grew more definite and stronger with increasing clinical opportunities, and a fuller knowledge of the natural history of the disease, until it became a motive, impelling me to cast about for some different and more satisfactory plan. This feeling has been, during the past decade, a very general one in the profession in all parts of the world, as is attested by an almost endless succession of journal articles setting forth new plans of treatment, and the use of new drugs, in the management of this, the most common and most important of the acute infectious diseases of the present epoch in medical history. Most of the plans thus suggested have led to disappointment when tested by the fuller observations of the profession; many of them have failed to attract general attention, and some few are still *sub judice*. Their number and diversity bear witness to a widespread distrust of the once well-established expectant treatment. This distrust is, however, based upon something more tangible than a mere feeling of dissatisfaction. The statistics of all observers whose cases have been sufficiently numerous to be trustworthy, show enteric fever to be, when treated by the expectant plan, a disease of high death-rate.

The per centage of fatal cases rarely falls below 15 per cent., and often exceeds 25 per cent., according to the hospital records of this country, Great Britain, and Continental Europe. Jaccoud, with a collection of 60,000 cases, observed a mortality of 20 per cent.; Murchison, in 27,051 cases, 17.45 per cent.; Liebermeister, in 1,718 cases, at Basle, under an expectant plan, records 27.3 per cent. of deaths. But turning from broad generalizations to personal experience, who is there here that many times, elated by the happy issue of mild or average cases treated by the expectant plan, has not realized the sense of utter powerlessness attending it when he has stood face to face with cases in which *to do* rather than *to wait* has been necessary to save life.

2. Enteric fever is the very type of the general diseases, of affections *totius substantiæ*. The tissues are universally implicated in the morbid processes; no function of the body wholly escapes perturbation. For this reason plans of treatment suggested by the prominence of certain groups of symptoms, or by the known lesions of particular organs, even though of undoubted benefit as far as they go, are in theory unsatisfactory because they are directed in effect against conspicuous manifestations of the cause of the sickness, rather than against the cause itself.

Whilst in actual practice the treatment by turpentine, by alcohol, by opium with lead, or the silver nitrate, or by agents capable of controlling the febrile movement, as quinine, digitalis, salicin and the salicylates, even the cold-water treatment itself, although at times and in the hands of certain clinicians, showing favorable results—all these have failed of general acceptance on the part of the profession.

3. The general character of the dis-

ease, the specific nature of its cause, the unsatisfactory results alike of an expectant and of a symptomatic plan of treatment, or rather of the two combined, have united to render the idea of a specific treatment, a true cure for enteric fever, a most attractive one, to stimulate thoughtful observers to renew again and again the disappointing search for it. To this idea may be traced the treatment by the mineral acids, by chlorine-water, by carbolic acid, by quinine alone, by quinine and digitalis, by iodine, by the potassium iodide, by calomel.

4. Not only is the conception of a specific treatment for specific diseases a most attractive one, and the attainment of such a treatment for enteric fever brought within the bounds of a reasonable hope by the analogy of syphilis and the malarial diseases, but the search after it with due caution and judgment has also the warrant of the very highest medical authority.

Passing by some earlier names, I refer to Da Costa, who has said: "It would be as illogical as absurd to suppose that we shall never possess the coveted means really to cure the continued fevers. Doubtless to the physicians of the time of Charles V. the radical and specific treatment of the malarial fevers appeared as hopeless and remote as the radical and specific treatment of the continued fevers appears to the scientific inquirer of our day."

I refer also to Liebermeister, who, treating about 800 cases, part with calomel, part with iodine, had with the former drug a mortality of only 11.7 per cent., with the latter of 14.6 per cent. against 18.3 per cent. for cases treated without those remedies, but in other respects upon a similar plan.

Bartholow has also spoken in favorable terms of the treatment by iodine in combination with carbolic acid.

The treatment adopted is thus seen to consist of the use of the two remedies that are proved to exert a favorable influence upon the disease, iodine and calomel, with the addition of carbolic acid in minute amounts. I am aware that no positive conclusions as to the efficacy of particular plans of treatment can be deduced from a limited series of cases. I am also aware that few acute diseases show greater variations in intensity and in the per centage of mortality at different periods, and under different circumstances, than enteric fever. Nevertheless I have ventured to occupy your attention with this subject to-night, because the results of the treatment encourage me to hope that its discussion in this way will lead to its trial on a more extended scale. That it amounts to a specific treatment in the narrow sense, is not affirmed. It is tentative, provisional, but it is nevertheless to be regarded as a contribution to the subject of the specific treatment of enteric fever.

#### Treatment of Malarial Coma.

Dr. ARCH DIXON insists upon the hypodermic use of quinine in congestive chills, and says that any attempt to administer remedies by the mouth or rectum is only a waste of time, and results almost invariably in the loss of the patient. He inserts the quinine in warm solution deeply into the cellular tissue, and has never seen abscess or other bad effects follow its use. A bold employment of the wet pack is also urged.—*Southern Practitioner*.

#### Quinquina as an Antiperiodic.

Mr. G. T. McKEOUGH, M. B. (*Canada Lancet*) writes of his experience in the use of quinquina as a substitute for quinine. He says quinquina is a preparation said to contain fifteen per cent.

of quinia, and that the remainder contains the other alkaloids of the cinchona bark. He used the drug with twelve patients and declared that the results obtained merit further trial. He thinks it will prove as trustworthy as quinine, grain for grain. Thirty grains will cure an attack of typical tertian or quotidian ague. One decided benefit it has over quinine is the absence of any of the unpleasant symptoms of cinchonism. As to the mode of administering it, the drug is insoluble to some extent and therefore gritty and sandy. It is exceedingly bitter. From this it seems best to give it in capsules, wafers or suspended in acacia, elixir of tarax. co., etc. The remedy seems useful, and if what is claimed for it be true, it will prove a great boon to the quinine taking public. The price of quinine is so high that any good, cheap substitute will be hailed with delight by the malarial stricken districts of our country.—*Chic. Med. Review*.

#### To Hasten the Action of Quinine.

Dr. STARKE, in *Berliner Klin. Wochenschrift*, advises that before swallowing powder or pills of quinine, a weak tartaric acid lemonade be taken. This procedure not only greatly accelerates the solution and absorption of the quinine, rendering its physiological action much more prompt, but also obviates that unpleasant gastric irritation so common after the administration of large doses of this drug.—*Med. & Surg. Reporter*.

#### Antipyretic.

NIEMEYER strongly recommends the following in pneumonia and other inflammatory fevers:  $\mathcal{R}$  Sulph. quiniæ, grs. v.; tinct. digitalis,  $\mathfrak{m}$  xv.; phos. acid. dil.,  $\mathfrak{m}$  xv. M. Sig.: To be taken properly diluted once in four or six hours.—*Am. Med. Journal*.

**Pleurisy with Intercurrent Anasarca.**

Dr. ROSSIGNOL relates the case of a cavalryman, twenty-one years of age, who was admitted to hospital, suffering from a slight attack of bronchitis of the larger tubes. He had never had any severe illness. Eight days after admission he was seized with repeated chills, fever, sweating and pain in the chest. Pleurisy with effusion was developed on the left side. The disease ran its usual course, though somewhat slowly, during a period of five weeks. At that time slight œdema of the feet was noticed, but was attributed to the anæmic condition of the patient, and to slight obstruction to the circulation. On the following day, however, there was another chill with fever and sweating, and on the day succeeding that there was marked general anasarca. The heart was perfectly normal, and there was not the slightest trace of albumen in the urine. The fluid in the chest re-accumulated when the anasarca set in. The œdema gradually disappeared under appropriate treatment, and at the time the report was made (two months later) the patient was nearly well. Dr. Rossignol offers no satisfactory explanation of this curious occurrence.—*Archives Médicales Belges.—Med. Record.*

**Ichthyol in the Treatment of Articular and Muscular Rheumatism.**

Dr. RUDOLPH SCHRÖTER, of Hamburg, has discovered a peculiar oily compound, which he calls ichthyol. It is obtained from a bituminous substance found in certain fossiliferous rocks. This is distilled and treated with sulphuric acid. Dr. P. G. Unna states that its action in acute and chronic articular and muscular rheumatism is astonishing. Several of his colleagues report similar results. Ichthyol has

been used chiefly in skin diseases, psoriasis, etc.—*Monatshefte f. Praktische Dermat.—Ibid.*

**Subcutaneous Injections of Carbolic Acid in Muscular Rheumatism.**

The results of some investigations recently undertaken by BINZ would seem to show that the action of carbolic acid and other so-called antiseptics in preventing suppurative inflammation is due, in great measure at least, to the influence exerted by these substances upon the white blood-corpuscles. In certain experiments upon the mesentery of a frog, this observer ascertained that the migration of the white corpuscles was almost entirely prevented by applications of a very dilute solution (1 in 1600) of carbolic acid.

Led by a consideration of these results Dr. Edgar Kurz, of Florence, instituted some experiments in the treatment of muscular rheumatism by subcutaneous injections of carbolic acid. He reasoned that in this disease we have to do not merely with hyperæmia and serous exudation, but with plastic infiltration of the perimysium and migration of the white corpuscles of the blood. In proof of this assertion he instances the formation of rheumatic nodes in severe cases. This method of treatment was tried in three cases only, but in each the success was stated to have been remarkable. In one case of deltoid rheumatism marked relief of pain followed within an hour after ten injections of a two per cent. solution. After six injections on the following day the patient was cured. The second case was one of lumbago. The patient had had several previous attacks in which relief was obtained only by morphine. Twelve injections were made in the painful region in the morning. In the afternoon the patient ap-

peared in the doctor's office, complaining only of a slight inconvenience in free movements. The third case was one of rheumatism of the right lower extremity with sciatica. The patient had previously suffered for an entire winter. The present attack was of eight days' duration. The patient could with difficulty take a few steps, and suffered severely also at night. The treatment consisted in injections of a two per cent. solution of carbolic acid. At first twelve insertions were made each day, and the number was gradually increased to forty every day or every second day. After the second day the patient was able to stand upright and to walk with tolerable ease. The nights were restful. Fourteen series of injections were made and the patient was entirely relieved of pain. No symptoms of carbolic acid poisoning were observed even when forty insertions were made at one sitting, amounting to twelve minims of carbolic acid. Dr. Kurz states that the injections should be made into the muscle itself, and not immediately beneath the integument. In parts where there is considerable over-lying adipose tissue, as in the thigh, he plunges the needle perpendicularly into the limb as far as it will go. No pain is caused by a two per cent. solution, or at most only a very slight burning sensation. Each injection consists of fifteen drops of the solution, containing three-tenths of a minim of carbolic acid.—*Memorabilien*.—*Med. Record*.

#### Treatment of Erysipelas by Subcutaneous Injections of Resorcin.

Dr. T. F. BOGUSCH reports (*London Medical Record*), four cases of erysipelas which he successfully treated by hypodermic injections of a five per cent. solution of resorcin. Having marked the margins of redness with

ink, he made a number of injections around the whole inflamed region, along the line running outside of the mark, at a distance of about  $1\frac{1}{2}$  ctm. He used for each injection 0.25 cub. c. of the solution, always directing the needle toward the centre of the diseased part. As many as sixty-seven, twenty-nine, thirty-six, and seventy injections (at points nearly equally distant) were required in various cases to complete an elevated ring around the affected region, resulting from the blending of individual swellings produced by injections. In all cases the injections completely cut short the further spreading of the inflammatory process, the temperature rapidly falling to the normal level. No untoward symptoms were caused by this treatment, and no other treatment was used.

—*Ibid*.

#### Diet in the Treatment of the Gouty Dyscrasia.

Dr. WM. H. DRAPER thus concludes an article on the above subject (*Med. Record*), read before the New York Academy of Medicine:

The treatment of gout, based upon the theory that it is a neurosis, is chiefly successful in the acute arthropathic lesions of gouty origin. The treatment of the constitutional vice is more successfully managed upon the theory that it is due to suboxidation of foods. The treatment of the gouty dyscrasia involves primarily complete combustion of food, whether carbonaceous or nitrogenous, and has to be brought about partly by dietetic rules, partly by hygienic, and partly by medicinal treatment. The hygienic treatment embraces an abundant supply of oxygen, and the medicinal treatment the use of such drugs as facilitate oxidation, etc. The dietetic means involves the consideration of the quantity and the quality of the food best

adapted to maintain health and nutrition. It is impossible to arrive at anything more than a proximate estimate with regard to the quantity of food. It is variable, and must be proportioned according to the age of the individual and his surroundings, and the amount of work he is to perform, etc. In infants the amount of food required in proportion to the weight of the body is from three to five times that required for an average ordinary working adult. In the adult regard must be constantly paid to the protection to be secured against heat and cold, and to the occupation of the individual. Excess of food may be positive or relative—that is, it may be either more than can be assimilated, or more than is required. The relation of the qualities of food in the production of the gouty diathesis may be very striking, and deserve investigation, although they are less important probably than the quantity. The farinaceous, the oleaginous, and the saccharine foods are especially indicated for the production of heat. A nitrogenous diet is best constituted to maintain the health and nutrition of persons who do not require a large amount of animal heat, and whose occupations are mental rather than physical.

Leaving the consideration of the principles which should regulate the diet, Dr. Draper remarked that the almost uniform counsel with reference to treatment of the gouty dyscrasia is, that albuminous foods should enter sparingly into the diet of gouty patients, and that the non-nitrogenous foods, especially the farinaceous, should constitute the principal aliment. His own observation had led him to the conviction that the uric-acid theory of the gouty diathesis is not supported by the results of clinical experience, and he was persuaded that restriction of diet concerning

the non-nitrogenous rather than nitrogenous foods is essential. If there is one clinical fact more obvious than another in this class of patients, it is the limited capacity they possess for assimilating the carbo-hydrates, the sugars and the starches. These substances are the most common source of dyspeptic troubles. The clinical fact was well established that the conversion of the nitrogenous foods is rendered more complete when they contain a minimum amount of carbo-hydrates rather than by allowing the minimum amount of nitrogenous food.

The order of restriction in diet which he recommended was first with reference to sugars, especially in the state of fermentation, or ready to pass into that condition; second, farinaceous foods; and, third, fats.

Abstinence from all fermented preparations of alcohol was, perhaps, the most necessary in the order of restriction. There could be no question concerning the effects of malt liquors in the production of the gouty diathesis, especially of the stronger English and Scotch ales. The directions, therefore, with regard to fermented preparations of alcohol, should be very strict. The absolute prohibition of beer should be insisted upon, and the less wine allowed the better. Sherry, Madeira and port should be especially excluded. If alcoholics were indicated, the safest preparation which could be employed was very dilute spirit taken with food, and never upon the empty stomach. Saccharine food should be restricted. The common experience of the gouty individual confirms this statement.

The amylaceous elements were the next in order to be restricted, and pure starchy foods, such as potatoes, corn and rice, and even wheat and barley, provoke indigestion. According to his

experience, the fats were easily digested by most gouty dyspeptics. The value of milk in cases of persistent rebellious lithæmia was well known, and constituted a precious resource. Salads, cauliflower, cabbage, indeed almost all vegetables except those which are nearly all starch, may be used with safety. A person pursuing intellectual labor and leading an indoor life should take only a limited supply of food which requires oxidation, and had not better try puddings and the like, or endeavor to quench his thirst with beer or wine.

#### DISEASES OF THE NERVOUS SYSTEM.

##### A New Remedy for Spasms.

The *Med. Central. Zeit.*, publishes the results of experiments instituted by Dr. SCHIFFER, of Berlin, for the purpose of determining the therapeutic value of the extract of *Guachamaca*, a tree indigenous on the Apache mountains. As a specific for all spastic conditions of the motor apparatus we so far possessed, in reality, one remedy only; curare, which, however, on account of its danger, and the uncertainty of its action, as well as of the remedy itself, has mostly been used for physiological experiments alone, and, perhaps, occasionally in tetanus.

Guachamaca extract prepared from the bark of the Quebracho plant, which belongs to the same class as the Oleander (*Nerium ol. L.*) and of which latter the skin between tree and bark is also poisonous, is a remedy which, while not so dangerous in its effects, is far more reliable and uniform in its action, and can besides easily be procured pure and genuine, and of always equal strength, as it is by no means rare.

Schiffer experimented with this drug, and made his observations in the clinic

of Prof. Frerichs. He employed the remedy in solution, in the dose of one-sixth of a grain, and by the hypodermic method in cases of tonic and clonic spasms of the muscular system, and always with a very good effect. He noted also that, administered internally, no matter in what solution, the drug was as little absorbed by the mucous membrane of the alimentary canal as curare is.

Should further trials with this remedy prove invariably as successful, or at least frequently so, as was the case in Schiffer's experiments, we would at last possess a reliable specific for all spasmodic affections of muscles and motor nerves, a drug, the physiological action of which would be exactly opposite to that of strychnine and similar remedies. —*Med. and Surg. Reporter.*

##### Propylamine in Chorea.

Dr. J. H. CARSTENS, (*Detroit Clinic*). The exact pathological changes found in chorea not being known in all cases, or rather each case having a pathology and cause of its own, the result is that the treatment varies, that many divers remedies have been used with more or less success. I have seen cases caused by malaria and cured by quinine; cases caused by nicotinism and cured by appropriate treatment. In many cases we cannot find the cause, do not know the pathological changes which cause the symptoms and consequently must treat them empirically, in fact try one remedy and then another until we strike the right one. In most of the cases where we do not know what morbid changes have taken place, I have been able to cure by the use of arsenic and zinc.

Two years ago a girl thirteen years old, Lizzie I., had an attack of chorea, which I cured with the above remedies.

A second attack in February did not yield, and after trying other remedies also, I thought I would try propylamine. The result was most gratifying; the girl was soon cured.

Jos. E., æt. 11, was taken with an attack of chorea eighteen months ago. He dreamt one night that a dog was chasing a mouse and both ran down his throat, the fright brought on the attack as he had well marked chorea the next morning. He was treated for six months by various physicians without avail and then the disease gradually disappeared without treatment. In January, 1882, was suddenly taken with a second attack, which continued till April and was not treated at all. In the latter month he was brought to me and subjected to treatment. Various remedies were tried, arsenic, zinc, strychnine, iron, etc., but he did not improve. I then put him on propylamine as follows:  $\mathcal{R}$  Propylaminæ, 3 j.; aquæ menthæ piperitæ,  $\mathfrak{z}$  jss.; syrûpi simplicis,  $\mathfrak{z}$  ss. M. Teaspoonful three times a day.

He began to improve immediately and in two weeks was about well, but I made him continue to take the above remedy once a day for four weeks longer. He is now well and attends school. I could report more cases, but this is sufficient to again call attention to the remedy. The rheumatic diathesis is found in some cases of chorea, and perhaps that may account for the cure of some cases by propylamine.

#### Epilepsy.

M. MAGNAN (*Le Progr. Méd.*), speaking of epilepsy, says, that of all remedies the bromides are the most successful, and of these, potassium bromide. It should be given in solution with some aromatic or bitter vehicle. From 4 to 8 grm. must be given daily, and in severe cases 10 to 12 grm. The treatment

must be continued for several years. When the attacks lessen in frequency and severity, the treatment may be intermitted for five or six days occasionally, and later on for fifteen or twenty days. The system should be kept under the control of the remedy for years in this interrupted way. If bromide of potassium proves of no use as it sometimes does, then try other bromide, as silver or zinc. There are cases in which the bromides are quite useless. These should be treated with zinc, valerian, and good nerve tonics. When all these fail, much good may follow the constant use of the cold douch. He greatly favors the simultaneous use of a number of agents useful in the disease; and makes the remark that cases which resist the bromides, douching, salts of silver and zinc, when given separately, improve speedily when they are employed at the same time.—*Chic. Med. Review.*

#### Ergot in Delirium Tremens.

Dr. ARNOLDOW (*Deutsche Medicinal-Zeitung*) relates the case of a man suffering from hæmoptysis, who was also threatened with delirium tremens. Chloral had been given for the sleeplessness, but without effect. Upon the administration of ergotine, not only did the hemorrhage cease, but the symptoms of alcoholism also subsided. This happy result induced the author to give ergot in several other cases of mania-à-potu, in all of which the delirium was speedily controlled. Dr. Arnoldow explains this action by the contraction of the blood-vessels of the brain induced by ergot.—*Med. Record.*

#### The Cause of Tetanus.

Dr. F. SCHUTTZE reports in the *Neurol. Centrbl.*, the microscopical examination of the central nervous system

of four cases of traumatic tetanus. In all the cases, nothing was found which would have been characteristic for an acute meningitis or myelitis. Schuttze is with justice opposed to all vague publications of the post-mortem examinations of such cases, and mentions that whatever he had read, so far, of such reports, were simply normal post-mortem appearances, which could be noted in any dead body. The anatomical cause of this dreadful disease continues, therefore, still to be unknown.—*Med. & Surg. Reporter*.

#### Eserine and Belladonna in Tetanus.

Dr. LAYTON reports in the *New Orleans Medical Journal* a case of tetanus cured with the following prescription: Sulphate of eserine, one-half grain; pure glycerine, two fluid drachms; syrup of orange flowers, fourteen fluid drachms; water, two ounces. M. S.: Teaspoonful, which contained one-sixty-fourth grain or one milligramme of eserine, every hour. The glycerine was added to prevent the decomposition of the eserine, because this drug is affected even by exposure to the atmosphere. From January 10th, in the evening, the doses of eserine were given at intervals of an hour and a half; later, the time was increased to two hours; the remedy was continued until January 17th, when the child had taken, in all, three grains of eserine; the prescription was then discontinued, the only remaining trace of the attack being some rigidity of the jaws, which had entirely disappeared by January 30th.

Dr. Whiteley reports two cases of tetanus in the *British Medical Journal*, which he claims to have cured by belladonna in large doses. From twenty to thirty minims of the tincture were given every two hours.—*Med. Record*.

#### Excision of Superior Maxillary and Inferior Dental Nerves for Neuralgia.

In the *Pittsburgh Medical Journal*, Dr. WILLIAM WALLACE says: The fact that a new connecting medium sufficient to enable a nerve to perform its functions can be developed to the extent of an inch or more has been sufficiently attested. Any resection, therefore, which would embrace a less portion of nerve would in all probability be of only temporary benefit, unless the period of relief gained thereby would permit of such constitutional recuperation as would withstand any future attacks.

My experience in the operation of resection for neuralgia has been extremely limited, but the success attending my efforts has been so satisfactory that I venture to offer it as an inducement for a more extended application of this method of relief.

A severe case of neuralgia coming under his care, it was decided to resect a portion of the inferior dental nerve. The disc of bone removed by the trephine failed to expose the nerve, and the patient bearing either badly, it was decided to postpone further operative interference. Subsequently, both the superior maxillary and inferior dental nerves were excised.

The continuance of the pain for a few days after the operations and its return for a short time, seven months later, cannot well be accounted for. The clinical features of the case embraced all of the symptoms described by Trousseau as characteristic of epileptiform neuralgia, which he believes to be an expression of true epilepsy, a view scarcely confirmed by the history narrated. Entire and permanent immunity from pain, return of appetite, ability to take solid food and comfortable sleep, were secured by the operations.—*Ibid*.

**Neuralgia of the Stomach.**

℞ Bicarb. potassa, 3j.; acid hydrocyanic dil., sol. sulph. morphia, āā gtt. xxiv.; aqua camphor, ʒvj. Sig.: Teaspoonful as required.—*Louisville Med. News.*

**DIGESTIVE TRACT.**

**Function of the Bile.**

Generally the opinion has been adopted, that the bile possesses an anti-fermentative action. Dr. F. RÖHMANN (*Breslauer ärzsl. Zeitsch*) has specially investigated this subject. He had two dogs with the fistula of the gall-bladder; to both he gave for their food nothing besides meat, and he found the fæces grayish-white, dry, easily broken up, and consisting mainly of inorganic substances. In the urine of neither could be noted any increase of ethereal sulphuric acids, a fact which undoubtedly could have been observed in the intestinal canal in case putrefaction had been augmented. A third dog with a fistula of the same kind continued in a normal condition when fed for a long time with toasted white bread; but as soon as he was put on an exclusive meat diet, diarrhœa set in, which happened also when fat was added to his food. The fat under such circumstances is not absorbed, but is found again in the fæces, and mainly in the form of soap and free fatty acids.—*Med. and Surg. Reporter.*

**A New Means of Detecting Fatty Degeneration of the Liver.**

Drs. LÉPINE and EYMONNET describe a new method, of apparently some value, for determining the existence of fatty liver through examination of the urine. Their procedure is briefly as follows: Every trace of phosphoric acid, as ex-

isting in the phosphates, is removed from the urine by means of a mixture containing magnesia or of baryta water. The liquid is then evaporated and the residue calcined with potassium nitrate. If now this be redissolved in a little water acidulated with nitric acid, and treated as before with magnesia, it will be found that a minute quantity of phosphoric acid is still present. This comes from the decomposition, during the process of calcination of the glycerin-phosphoric acid, normally contained in the urine, which is a product of the decomposition of lecithin. In the normal condition glycerin-phosphoric acid is contained in the urine in very small amount—in proportion to the urea of 1 to 200. But in several cases of fatty liver, the authors state that they found it increased in proportion to the urea five or even ten-fold. The relation of these two conditions—fatty degeneration of the liver and an increase of the glycerin-phosphoric acid in the urine—they explain by the fact that the fat of the liver contains lecithin. They have found this product in fatty livers in the large proportion of three per cent. of the entire hepatic substance.—*Archives Médicales Belges.—Med. Record.*

**Cerebral Symptoms Produced by Ascaris Lumbricoides.**

Dr. SAMADA reports (*El Sentido Católico en las Ciencias Médicas*) a case in which severe symptoms were produced by the presence of a large number of ascarides lumbricoides. The patient was a lad about eight years old. His attack commenced with severe headache, attributed to a fall sustained a few days before. This was followed by photobia, conjunctival injection, and later by profound coma. Constipation was present, and, as a saline purgative did not produce an evacuation, calomel and

aloes were administered. This produced several evacuations, each containing about thirty ascarides. The head-symptoms ceased from the moment the bowels were purged, "as if by magic."—*Ibid.*

#### Local Therapeutics of Liver Diseases.

According to the experience of Dr. F. MOSLER and his pupils (*Deutsche Med. Wochenschrift*), the introduction of water into the bowel (by funnel and tube) caused a decided alteration in the secretion of the liver, by augmenting the percentage of water in the bile and reducing that of the solid constituents. Medicamental additions to the water, especially of salicylic acid and its salts as well as of iodide of potash, are excreted partially again by the bile. This manner of influencing the function of the liver, locally, does not recommend itself alone for icterus catarrhalis, for which it has mainly been made use of for some time already, but also in other diseases of the liver, as for instance in interstitial and suppurative hepatitis, and perhaps also in gall-stones, where, if early and frequently administered, these water injections, with or without the addition of appropriate remedies, may be able perhaps by augmenting the percentage of water in the bile and reducing that of its solid component parts, to dissolve them, or to keep the bile at least in such fluid state that the reformation of the stones would be prevented, and at last such a change produced in the chemical composition of the bile, that we might speak of a radical cure of gall-stones.—*Med. and Surg. Reporter.*

#### Influence Exerted by Various Agents Upon Digestion.

From a series of experiments undertaken to determine the rapidity of the digestive process in the stomach under

varying circumstances, Dr. FLEISCHER deduces the following conclusions: A pint of cold water, taken with the meal, exerts no influence upon digestion. A quart retards it somewhat, and the drinking of three pints causes a considerable retardation of the process. Walking for several hours at a tolerably rapid gait, lengthens the period of digestion. Hot poultices applied after eating materially hastens the process. Cold, in the form of ice-bags over the gastric region, produces no effect. Dilute hydrochloric acid and pepsine produced no effect upon digestion, either in healthy individuals, or in patients suffering from dilatation and catarrh of the stomach. These remedies in combination with hot poultices over the stomach accelerated the process of digestion.—*Allgem. Med. Central-Zeitung.*—*Med. Record.*

#### Hypodermic Injections of Morphine in Seasickness.

According to Dr. COELHO (*Allgem. Med. Central-Zeitung*), seasickness is promptly controlled by subcutaneous injections of morphine in the epigastric region, in doses of one-eighth to one-sixth grain.—*Ibid.*

#### Sugar of Milk as a Laxative.

TRAUBE recommends sugar of milk as a mild and trustworthy laxative in doses of two or three drachms, dissolved in half a tumbler of warm milk, taken before breakfast.—*Ibid.*

#### Proctitis from Plum-Stones.

A case is recorded in the *Deutsch. Med. Wochenschrift* where proctitis and paralysis of the anus was found to be due to the impaction of plum-stones, of which one hundred and thirty-seven were removed. Cold water injections and castor oil completed the cure.—*Mary. Med. Jour.*

# DISEASES OF RESPIRATORY ORGANS.

## Asthma.

DR. WILLIAM M. WELSH (*Medical Bulletin*) gives the following formula for the treatment of asthmatic attacks:  $\mathcal{R}$  Stramonii foliarum, 3 x.; potassæ nitratis, 3 v.; seminis fœniculi, 3 ss.; sacchari, 3 ij. M.

The stramonium leaves and the fennel seeds should be ground to a powder, not very fine, and passed through a sieve so as to get rid of the stems and coarser fragments. All the ingredients should then be rubbed together in a mortar, without producing a very fine powder. The mode of using the material is to place a small portion of the powder on a dish and ignite it with a match. It should burn slowly and somewhat irregularly, emitting fumes as it burns, which, of course, are to be inhaled. The fumes may be conducted to the mouth of the patient by means of a paper hood placed over his head. It combines, the author claims, the good effects of nitre and stramonium.

## Massage in the Treatment of Catarrhal Laryngeal Croup, and Diphtheritic Angina.

BELA WEISS' method has been found by the author to be recommended, and is as follows: The throat alone is to be manipulated by placing the three fingers on the larynx and moving gently at first, with greater force afterward, to the maxillary angle. The manipulation lasts from five to six minutes, and is repeated every two or three hours. The effect is noticed at once in the diminished pain on swallowing, and in cases in which the manipulations are instituted at the onset of the disease, violent diphtheritic symptoms rarely occur; if such symptoms are already present, they are at once alleviated.

After each manipulation diphtheritic mucous masses are expectorated, the hoarseness gives way, and euphoria generally begins.—E. Freund, *Deut. Med. Wochenschr.*—*Teraph. Gazette*.

## Ethyl Bromide Internally for Spasmodic Cough.

Dr. SQUIRE recommends a solution of bromic ether in water (1 to 200) for administration in whooping cough, as well as for angina pectoris and spasmodic pain. It may be given in the same manner as the aqua chloroformi of the British Pharmacopœia.—*Med. Record*.

## Treatment of Enlarged Tonsils.

The *Medical News*, quoting from the *Lancet*, relates the following expedient when the tonsils are enlarged and when excision cannot be performed. Dr. GORDON HOLMES advises a method of applying the common caustic to the tonsils, which appears to have remained hitherto unnoticed. The tonsil, as the anatomist knows, is permeated by several rather large channels around which the follicles are collected, opening on the pharyngeal side of the gland, whence its characteristic cribriform aspect. Their orifices, about seven to fifteen in number, are sufficiently evident to be counted on the healthy tonsil in situ, whilst in the hypertrophied condition these openings increase greatly in calibre and depth, and can be ascertained by a probe to vary from one-eighth of an inch to half an inch in length, with a diameter capable of admitting a style of ordinary size. These observations, then, afford a valuable indication for treatment; for through these natural canals a way lies open to attack the heart of the gland in a most efficacious manner with caustics. Thin pointed sticks of nitrate of silver or chloride of

zinc can easily be pressed into the lacunae and worked around for a few seconds. Small sloughs are thus formed, which are soon discharged, and in the process of this treatment the tonsils are hollowed out in one direction whilst being contracted into much smaller bulk by the subsequent cicatrization in another. Two or three channels in each tonsil can be cauterized daily or on alternate days, and we can thus act on a comparatively large surface whilst causing but slight external soreness and little or no suffering to the patient. In practising this method, although the stronger caustics may be used, he does not think it will be necessary to have recourse to anything more potent than nitrate of silver, which acts much more effectually on the tender, internal structures of the tonsil than when applied to the comparatively callous pharyngeal surface.—*Chic. Med. Review.*

#### Administration of Aspidospermine.

EULENBERG, in the *Medicinal-Kalendar* for 1883, gives the following formula for administering the active principle of quebracho, which, it has been claimed, may be used with benefit in all forms of dyspnoea without regard to the cause:  $\mathcal{R}$  Aspidospermine, 1 grm. (gr. xv); aquæ destillatæ, 50 grms. (f  $\frac{3}{4}$  jss); acidi sulphurici, q. s. ad solve. M.

Dose, 1 gramme (15 minims), containing 2 centigrammes (gr.  $\frac{1}{4}$ ) of the remedy, or more.—*Le Progrès Médical.*—*Mary. Med. Jour.*

#### Early Diagnosis of Pulmonary Tuberculosis.

The *Medical News*, in an extract from *L'Union Médicale*, says: "That more value than has heretofore been believed can be attached to the presence of anomalous respiratory movements in the early diagnosis of tuberculosis of the lungs; and when the irregularity is

localized in the apex of the lung, particularly on the left side, and is permanent, it permits of a positive diagnosis, seen in the absence of other signs, such as crackling or alterations in the vocal fremitus or pulmonary resonance. These respiratory anomalies, in the order of their importance, are rough and deep inspiratory murmur, feeble and jerky respiratory movements. Harsh and deep-toned inspiratory murmur is the most valuable sign, as it is the earliest which appears."

These points, which Dr. Grancher calls attention to, are of undoubted value to the early diagnosis. The only point on which we would differ is the fact of the doctor laying particular stress on the localization of these anomalies in the left apex: private statistics of ours on a hundred cases of early or incipient phthisis show quite a respectable majority in which these signs were confined for a time to the right apex alone, the left only becoming tuberculous after a time.—*Med. and Surg. Reporter.*

#### Inhalation of Medicated Vapors in Diseases of the Respiratory Organs.

GUILLEMEN (*Archives Méd. Belges.*—*Lond. Record*) summarizes his views as follows:

1. The affections of the mucous membrane of the respiratory passages may in certain cases be advantageously treated by inhalations of medicated vapors.
2. In the first stage of acute inflammation of this mucous membrane, pain, cough and painful sensations, which are the consequence of irritation and dryness, are rapidly calmed by inhalations of warm, moist and aromatic vapors.
3. The calming action is still more decided if to the liquid, which serves

for inhalation, there be added a small quantity of certain volatile calmate substances, such as ether, distilled cherry-laurel water, or conium.

4. Frequently renewed inhalations of essence of turpentine, when they are administered at the commencement of the first period of inflammation, may arrest its progress.

5. The vapor of iodine exercises an irritant action on the mucous membrane of the air-passages. It induces efforts of coughing and augments the secretion of the mucus of the air-passages. This irritating action may be utilized: (a.) To diminish the swelling of the mucous membrane by causing the inflammation to pass from the first to the second stage; this indication is present especially in cases where the inflammation occupies the small bronchi; the swelling of the mucous membrane is sufficient to give rise to fear of respiratory insufficiency. (b.) To diminish the viscosity of the products of morbid secretion by their admixture with the mucus, of which the vapors increase the formation. (c.) To induce efforts to cough and to disembarass the air-passages from the products which are there accumulated.

6. It is not only by its irritating properties that the vapor of iodine modifies the mucous membrane of the air-passages. Iodine in reality possesses the property of stopping purulent secretion, and, on the other hand, it arrests and prevents putrescence. Thus, when the mucous membrane of the air-passages yields a purulent secretion, resulting either from an acute inflammation in the third stage, or from a chronic inflammation, the inhalations of iodine will determine by degrees the quantity of pus, and finish in certain cases by entirely changing the nature of the se-

cretion, which becomes completely mucous.

7. Although the essence of turpentine, in the fluid condition, is a sufficiently powerful irritant for the tissues with which it is placed in contact, inhalation of this essence is easily supported by the mucous membrane of the air-passages. It only brings on very moderate irritation, and very rarely provokes fits of coughing.

8. When the mucous membrane is affected, and yields a product of secretion, these vapors have the effect of diminishing the quantity and augmenting the consistence of this.

9. If the product of secretion be purulent, the inhalation of essence of turpentine, continued during a sufficiently long time, progressively diminishing the quantity of pus, may, in certain cases, completely stop the secretion. The inhalations are indicated in all affections of the larynx, of the trachea, and of the bronchi, when accompanied by a very copious muco-purulent secretion without viscosities. On the other hand, the use of them must be avoided whenever expectoration is difficult, in consequence of the too great viscosity of the products of secretion.

10. In cases when these products are at the same time very copious and very viscous, it is possible, by alternate inhalations of vapors of iodine and vapors of turpentine, to rapidly diminish the quantity of secretion without increasing its viscosity. The inhalation of iodine should always be used in the first instance.

11. Inhalation of essence of turpentine is indicated in hæmoptysis, and is very successful in cases of hæmoptysis of average intensity.—*Detroit Lancet*.

### DISEASES OF THE CIRCULATORY ORGANS.

#### Convallaria Maialis in Heart Disease.

Dr BERTHOLD STILLER has met with very indifferent success in the treatment of heart disease with convallaria. He reports upon twenty-one cases of various forms of disease, in patients aged from eleven to seventy years. The drug was administered in infusion ( $\frac{3}{4}$ —1 to the pint) in tablespoonful doses every two hours. In seventeen of the cases absolutely no results were obtained. In two there was a slight increase in the amount of urine, but no improvement in the other symptoms, and no diminution in the anasarca. Indeed, in one case, the œdema actually increased during the administration of the remedy. In one case of weak heart with general anasarca, a slight improvement was noticed after the convallaria had been taken for twelve days. The pulse was diminished in frequency and strengthened; the œdema of the scrotum, though not of other parts, subsided, and the patient expressed himself as feeling better. In another case of mitral and aortic insufficiency with general anasarca, digitalis had been taken for some time, during which the symptoms became worse. Convallaria was now given with apparently good result. The dyspnœa was lessened and the excretion of urine increased, but there was no improvement in the irregular action of the heart or in the dropsy. The reporter raises the question, however, whether even this slight amelioration may not have been due to a cumulative action of the digitalis previously administered. From these experiments Dr. Stiller concludes that convallaria, so far from being an efficient substitute for digitalis, is not worthy of even ranking as an adjuvant to this remedy in cardiac disease. He admits, however, that the

specimens of convallaria used by him may have been of quality inferior to that employed by other observers, who have reported such brilliant results.—*Wiener Med. Wochenschr.*—*Med. Record.*

#### Acute Endocarditis Limited to the Right Side of the Heart.

COLOMIATTI (*London Medical Record*) describes five cases of acute endocarditis of the tricuspid valve. Having shown that these are not so rare as is supposed, he points out that the affection may fall on the tricuspid or on the pulmonary sigmoid valves only, or on both at the same time; that it may be perforating in one orifice, whilst it is as a vegetation in the other; that it has nothing to do with sex or age, being found in infants, and in youth and old age in both sexes. From a sixth case he infers that endocarditis may affect only the right parietal endocardium, and from their first origin the vegetations may be limited to the right auricular appendage. In all the cases the microscopical examination of the vegetations showed that they consisted of embryonic connective tissue, the elements of which were for the most part in a state of fatty degeneration. The vegetations were very easily torn, and frequently gave origin to pulmonary emboli.—*Ibid.*

#### Cardiac Hypertrophy Consecutive to Neuralgia of the Arm.

Dr. POTAIN relates several cases in which neuralgia of the left arm, due to traumatism, was followed by hypertrophy of the heart. He explains the occurrence by the nervous connections existing between the cardiac plexus and the brachial plexus, and remarks upon the reverse conditions which obtain in cases of angina pectoris.—*Archives Médicales Belges.*—*Ibid.*

# CONSTITUTIONAL DISEASES.

## The Frequent Repetition of Doses.

DR. A. A. SMITH, Professor of Mat. Med. in Bellevue Hosp. Med. Coll., contributes a valuable paper on this subject to the *New York Med. Jour.*, from which we take the following :

Chlorate of Potash.—Grain doses every half hour in scarlet fever, diphtheria, tonsillitis, etc., will produce the same results as larger doses, without the danger of the evil effects resulting from the accumulation of the drug in the system, as sometimes happens when it is administered in the ordinary way ; viz., dangerous inflammation of the kidneys. It is better, when giving croton chloral for neuralgia to administer a grain every half hour, than in larger doses. A solution, of which a teaspoonful represents one grain, will have scarcely any bad taste. Another advantage is, that being so largely diluted, it will be harmless to the mucous membrane of the stomach.

Two grains of the salicylate of sodium every hour or half hour in a teaspoonful of water, will cure the most obstinate cases of urticaria, except those of a chronic nature, and where it has been caused by full doses of balsam of copaiba, single grain doses of the same drug every half hour will sometimes control it.

Fowler's solution, or the liquor potassii arsenitis, half a drop given every half hour, for six or eight doses, will often relieve the vomiting which occurs after a debauch. It will also relieve the morning vomiting of drunkards, and it is of decided benefit in the sympathetic nausea and vomiting of pregnancy.

Five to ten minim doses of the fluid extract of jaborandi every hour or half hour will produce copious perspiration,

without causing any unpleasant effects upon the heart, especially if combined with digitalis.

In supposed croup, which is usually false croup of a reflex origin, a teaspoonful of a solution of one one-hundredth of a grain of sulphate of atropine in a tumbler of water, every hour or half hour, will give relief.

If the child's face begins to flush and show signs of the physiological effects of the drug, the dose can be reduced in frequency. Do not forget in these cases to give an emetic if there is anything in the stomach which may be causing the spasm, or a cathartic, if there be reason to suspect intestinal disturbance as the cause.

In nervous disturbances and undefinable and transitory disorders of children, the bromides, in doses of one or two grains every ten or fifteen minutes, will often prove of great benefit.

You will often meet with children of a nervous, excitable frame of mind, who are, perhaps, naturally of a sensitive, nervous temperament, who are disturbed by the slightest noise, and are unable to go to sleep before ten or eleven o'clock at night. In such cases you will find it necessary to give a nervous sedative. An excellent effect will be produced by chamomilla in some one of its forms as the tincture, administered in minim doses, every fifteen or twenty minutes. Put a teaspoonful in half a tumbler of water, and let the child drink it freely.

A single drop of the wine of ipecac, repeated every fifteen or twenty minutes, will often produce the most marked relief, both from vomiting and diarrhoea. Administered in this manner, the drug is not nauseous, and is easily taken.

I now make a statement, upon the authority of Trousseau and his enthusi-

astic successor, which may appear to you, as it once did to me, incredible—viz., that one-sixtieth of a grain of calomel, taken every hour for ten or twelve hours, will relieve the headache of syphilis occurring at night. I have administered it in one-fortieth-grain doses in this manner, and have obtained the results which they claimed for it, but I have not yet tried it in sixtieth-grain doses. The relief was very marked by the second or third night. It is not intended to take the place of iodides which are given in such cases.

Nursing children often vomit or regurgitate their food ; teaspoonful doses, every ten or fifteen minutes, of a solution of one grain of calomel to a pint of water, will often relieve this. One twenty-fourth of a grain of mercury with chalk, every fifteen or twenty minutes, is of great benefit in the vomiting and non-inflammatory diarrhoea of children.

Where the diarrhoea is accompanied by mucous passages, indicative of a certain degree of inflammatory action, or enteritis, benefit will be derived from the administration of one teaspoonful of a solution of bichloride of mercury (corrosive sublimate), one grain to the quart, every hour.

Another extraordinary statement, which at first seemed to me to be fabulous, and may seem so to you, but which, nevertheless, you will find to be based upon clinical facts : Put a grain of tartar emetic into one quart of water ; teaspoonful doses of this solution every half hour will prove effectual for the relief of the wheezing and cough accompanying a slight bronchitis in children.

A single drop of the tincture of *nux vomica* given every ten minutes will often produce most marked relief in sick headache not of a neurotic

origin. It should be given immediately after or soon after meals.

It is well known that cantharides, when given in large doses, is liable to cause inflammation of the urinary tract ; but it has been found that a single drop of the tincture every hour will in many cases relieve vesical catarrh.

A single drop of the tincture of *digitalis*, given to a patient suffering from symptoms due to organic heart disease when *digitalis* is indicated, administered at intervals of an hour or half hour, according to the severity of the symptoms, will often give greater relief than larger doses, and without liability to ill-effects.

For the diarrhoea of children, accompanied with slight inflammation, straining, and the passage of jelly-looking matter, but not true dysentery, five drops of castor-oil, given every hour in water with sugar and gum, is an excellent remedy.

In orchitis and epididymitis and dysmenorrhoea, not of a membranous, obstructive, or neuralgic character, two minim doses of tincture of *pulsatilla* every hour will afford greater relief than any other mode of treatment. For flatulence, fluttering, and palpitation at the menopause, one-fiftieth grain doses of the extract of Calabar bean every half hour for six or eight doses, and similarly repeated after stopping it for three hours, will prove an effectual remedy. In amenorrhoea not due to anæmia, minim doses of the fluid extract of *ergot* every half hour for five or six hours, the day before, and again on the day on which it should occur, will be beneficial. There are many cases of febrile movement, with dry, hot skin, a full bounding pulse, the mucous membrane of the throat and nose probably dry—cases in which the febrile movement is not the commencement of one of the continued fevers ; the tincture of *acon-*

ite, one-third to one-half a minim given every fifteen minutes, will be found of decided benefit. Visiting the patient shortly after the commencement of this treatment, you will often find him in a little perspiration; the medicine may then be administered at longer intervals, every half hour or longer, according to the indications. The tincture of aconite, administered in a similar manner, is also useful in cases of commencing so-called cold in the head. It is likewise useful in cardiac hypertrophy with palpitation, severe headache, and disturbances of the nervous system due to increased force of the heart-beat.

Two minims of the tincture of hamamelis every half hour will often control hæmorrhages.

The tincture of belladonna in minim doses, given every half hour, is a good remedy in cases of nasal catarrh, and bronchitis accompanied by free secretion. You should cease to give the drug for a while after eight or ten doses have been administered, as it is less quickly eliminated from the system than the other medicines of which we have already spoken. In cases of pulmonary œdema with failure of heart power, belladonna thus administered is of benefit in retarding the exudation of serum, and in overcoming the failure of heart power.

Two grains of the chloride of ammonium, combined with ten or fifteen minims of the tincture of cubebs, given every half hour, oftentimes controls acute pharyngitis and superficial inflammations of the other tissues about the throat. For inflammation of the throat dependent upon a gouty diathesis, add to this mixture ten minims of the ammoniated tincture of guaiac, and administer every hour.

In the headache of migraine, one grain of the citrate of caffeine given

every half hour, will often produce most marked relief.

In neuralgias about the face or head, three minim doses of the tincture of gelseminum every half hour will often act almost miraculously, and leave no ill-effects.

For certain kinds of headaches (especially those which are periodical, and not of malarial origin), fifteen minim doses of fluid extract of guarana given every fifteen minutes, will very frequently relieve. If it does not relieve in four doses, increase the dose to thirty minims.—*Med. & Surg. Reporter.*

#### Is Tuberculosis a Parasitic Disease?

This question has not yet been answered, but experimental data, so far furnished, will be of service to the medical profession in settling the question.

The following are the results of some of the investigations of GEORGE M. STERNBERG, M. D., as given in the *Medical News*:

[a] The bacillus described by Koch has been found in the sputa of phthisical patients in San Francisco.

[b] That this bacillus differs from the micro-organisms found in the normal human saliva and in bronchitic sputa, is proved by the color-test (Ehrich's) and by culture-experiments (see below, *i* and *g*).

[c] Tuberculosis in animals may result from inoculation—subcutaneous—with the sputa of tuberculous patients.

[d] But in several of the animals experimented upon, no evidence of tubercular deposit was found, and in others it was very slight. Total number of animals experimented upon, twelve rabbits, two guinea-pigs, and two dogs.

[e] In the animals successfully inoculated, the enlarged tuberculous lymphatic glands in the vicinity of the point of inoculation, and tubercular nodules

in the lungs and elsewhere, *usually* contained the bacilli of Koch.

[f] But this was not invariably the case. At least a careful search failed to demonstrate the presence of this bacillus in the tubercles found in the lungs of three rabbits.

[g] The bacillus of Koch was found in abundance in the tubercular nodules from a freshly-cut section of human lung.

[h] But in a similar specimen from another case, repeated examination failed to demonstrate the presence of the bacillus.

[i] Culture experiments have demonstrated that the bacillus in question multiplies upon the surface of sterilized and jellied blood-serum, prepared in the manner described by Koch.

[j] But in the writer's experiments the bacilli have not penetrated the culture medium, or extended upon its surface to such an extent as to indicate that multiplication was at the expense of this jellied blood-serum, which has seemed rather to serve as a *moist*, supporting surface; multiplication has apparently been at the expense of the tubercular material introduced for the purpose of inoculating this culture-medium.

The bacilli were not abundant in this material when it was first obtained from the lungs, or from an enlarged lymphatic gland of a rabbit recently killed; and after remaining in the culture-tube for a fortnight the bacilli were found in enormous numbers, while the cellular elements of the tuberculous material had to a great extent disappeared.—*Med. & Surg. Reporter*.

#### Another Cause of Phthisis.

H. STRUVE (*Wien. Medicin. Woch.*), on the cause of phthisis, says that, in his opinion, in many cases, it is due to severe irritation of the vaso-constrictors

of the bronchial arteries. In this way serum and blood corpuscles escape from the capillaries. The serum is afterwards absorbed, while the corpuscles remain and are the starting point of tubercles. His treatment consists in giving agents to reduce blood pressure, so as to prevent further deposits, and to aid in the removal of those already existing.—*Weekly Med. Review*.

#### Mullein Plant

Is said by F. J. B. QUINLAN, in the *British Medical Journal*, to have been from time immemorial a popular remedy in Ireland for the treatment of phthisis. He relates seven cases where it has been beneficial. He says:

"The mullein plant boiled in milk is liked by the patients; in watery infusion it is disagreeable, and the succus is still more so. The hot milk decoction causes a comfortable sensation, and when once patients take it they experience a physiological want, and when the supply was once or twice interrupted complained much in consequence. That it eases phthisical cough, there can be no doubt; in fact, some of the patients scarcely took their cough mixtures at all—an unmixed boon to phthisical sufferers with delicate stomachs. Its power of checking phthisical looseness of the bowels was very marked, and experiment proved that this was not merely due to the well-known astringent properties of boiled milk. It also gave great relief to the dyspnoea. For phthisical night-sweats it is utterly useless; but these can be completely checked by the hypodermic use of from the one-eightieth to one-fiftieth of a grain of atrophina sulphate; the smaller dose, if it will answer, being preferable, as the larger causes dryness of the pharynx, and interferes with ocular accommodation. In ad-

vanced cases it does not prevent loss of weight. In pretubercular and early cases of pulmonary consumption, mullein appears to have a distinct weight-increasing power. In early cases the mullein milk appears to act very much in the same manner as cod-liver oil, and when we consider that it is at once cheap and palatable, it is certainly worth a trial."—*Ibid.*

**A Case of Typhoid Fever Treated with Ergot.**

F. JACKMAN, M. D., (*Columbus Med. Journal*): Ella B., aged 10 years, light complexion, mild temperament, and rather delicate, had been sick in bed three days, when I first saw her, with fever in the afternoon, intense headache, occasional epistaxis, anorexia, considerable jaundice, bowels not moved for three days, and slight right iliac tenderness and gurgling on pressure. Temperature at 7 A. M.,  $104\frac{1}{2}^{\circ}$  F.; pulse 110. Thinking I had a malarial trouble, I ordered two grains of calomel and one grain of compound jalap powder until a good movement of the bowels took place; at the same time three grains of quinine and one-eighth grain capsicum was given every three hours. The next morning the temperature was  $102^{\circ}$  F., pulse 106, and in the evening temperature  $104\frac{1}{2}^{\circ}$  F., pulse 110. The purgative had produced considerable action of the bowels. The tenderness and gurgling in the right iliac region was more marked. Being satisfied that this was a case of pure typhoid fever, I discontinued the prescriptions and wrote the following:  $\mathcal{R}$  Quininæ sulph. grs. viij.; acid, salicylici, ext. ergotæ, aa. grs. xvi.; M. Ft. capsules no. viij. Sig.: One every three hours.

This was alternated every three hours with five drops of dilute nitrohydro-

chloric acid in water, making a dose every hour and a half.

Next morning the temperature was  $101\frac{1}{2}^{\circ}$  and pulse 110. In the evening, temperature  $104^{\circ}$ , pulse 110. The treatment was continued one week in this manner, together with cold baths in the afternoon and evening, the patient being put into a tub of cold water and thoroughly bathed, during which time the temperature gradually diminished until the evening temperature was  $100^{\circ}$  F.

One notable feature of the case was that the pulse kept up to 110 in the morning and 116 in the evening throughout the whole course of the disease—twenty-one days—but was strong and full. Thinking the fever was about to an end, I left off the capsules and ordered:  $\mathcal{R}$  Spts. terebinth,  $\mathfrak{z}$  j.; mucil. acaciæ,  $\mathfrak{z}$  ij.; M. Sig.: Teaspoonful every three hours.

The acid was continued. The next evening temperature was  $104\frac{1}{2}^{\circ}$ , pulse 116 but weak and thready. Diarrhœa excessive, with pain in abdomen, anorexia complete, and some delirium. The appetite during the past week had been good, and the patient was nourished with the usual typhoid diet. Regarding it as a temporary reaction the treatment was continued another twenty-four hours, when I found her in much the same condition. The turpentine was replaced with the ergot capsules and continued five days, during which time the symptoms above referred to all gradually diminished until the evening temperature was  $99\frac{1}{2}$ , pulse 116 and strong. The appetite returned and diarrhœa stopped the day after the continuation of the ergot. Again I left off the capsules and gave the turpentine as before, only to find the temperature at the end of twenty-four hours  $104\frac{1}{2}^{\circ}$ , pulse 116 and thready, anorexia, great

pain in the bowels, great diarrhœa and considerable hemorrhage with every passage. Resumed the ergot capsules, with the same result as before, until the end of twenty-one days, when recovery had unmistakably taken place and all medicine was left off.

I should have stated that whiskey was given *ad libitum* throughout the course of the disease. I should be inclined to think that the quinine and salicylic acid exerted some influence, if I had not before tried them in all my other cases, both separate and combined; and in both large and small doses, without any apparent benefit. Possibly it was the combination that was so beneficial.

#### Signs of Convalescence in Typhoid Fever.

The occurrence of multiple superficial abscesses, and that of polyuria, are two signs of convalescence in typhoid, according to Dr. CHAUFFARD in a recent communication.—*La France Médicale*.

#### Typhoid Fever.

Prof. W. K. BOWLING says in *Southern Practitioner*:

Now, if according to Wood, turpentine will cure typhoid fever in its worst stage, it ought to cure it in the best, and prevent the worst from occurring, and this we know it will almost always do. Leaving out the turpentine we can most conscientiously say with Nathan Smith, "medicine in this fever does more harm than good," and that which does the most harm is calomel.

The writer for a long time has risked the lives of his typhoid patients on turpentine, only this and nothing more. His formula is: R Sugar, 2 drachms; gum arabic, 2 drachms; ol. turpentine, 2 drachms. Mix and thoroughly triturate in a mortar, and during the process slowly add four ounces of cinnamon

water. Sig.: One teaspoonful every four hours.

We allow the patient a bountiful supply of good, cold butter-milk, religiously avoiding those most innocent articles, beef-tea and chicken-water, while true as steel to all the laws of hygiene. If cordials are indicated, egg-nog, with the egg always left out. The dose is for an adult, to be graduated to the ages of children.

As soon as we ascertain a fever submitted to our care to be typhoid, we immediately resort to this medicine. If the patient has diarrhœa, we look for the number of discharges to diminish every day till it ceases—opium for the loose bowels always produces head symptoms of a most unpleasant character.—*Med. Brief*.

#### The Organisms of Typhoid.

MARAGLIANO of Genoa has published in the *Centralb. für die Med. Wissenschaft*, an important note on the uniform occurrence of organisms in the blood of patients suffering from typhoid. He has found them in the blood of the spleen as well as in that of the general circulation. The blood was obtained by means of a hypodermic syringe, the needle of which was passed through the abdominal wall into the substance of the spleen. Dr. Sciamano of Rome first showed that blood may be thus obtained from the substance of the spleen during life without any injurious consequences. The blood of the general circulation was taken from the tip of the finger. In each method every precaution was taken to avoid the accidental introduction of organisms. The examination in this way of fifteen patients gave the following result: At the height of the disease the blood of the general circulation contains micro-organisms both isolated and grouped. These consist, almost exclu-

sively, of spherical bodies, which have a delicate contour, appear to be homogeneous, and are analogous to micrococci. Some of them are mobile. Similar organisms, again, were seen in the blood of the spleen, and in it, too, were others, rod-shaped, also with delicate outlines perfectly corresponding to those described by Eberth and Klebs. During convalescence these micro-organisms lessen in number in both the splenic and systemic blood. When quinine was given to the patient in large doses the organisms either disappeared from the blood or were present in it only in small number. The blood from both the finger and the spleen was treated by the method of fractional culture, and a large number of rods were then obtained, similar to those seen in the fresh blood, except that some of them were of greater length. The presence of such organisms in the blood of the spleen after death had been previously established by Sokoloff and Fischel; Maragliano is the first who has demonstrated their presence in the splenic blood during life. He avoids the expression of any opinion as to their relation to the disease.—*Lancet*.

#### Five Cases of Transfusion of Blood Into the Peritoneal Cavity.

PONFICK has demonstrated by experiments that any quantity of defibrinated blood injected into the peritoneal cavity will be absorbed with great benefit by any animal. Korzarowski, of Posen, has made these injections in five cases on the human person, with the best results. (1). Nephritis, articular affections, fever, profound anæmia. Two injections of 500 grammes of defibrinated blood into the peritoneal cavity, cure. (2). Nervosity, hysteria, spinal irritation and anæmia. One injection, radical cure. (3). Phthisis well devel-

oped; after the first injection the appetite returns, fever and night-sweats disappear. (4). Anæmia, extreme weakness, patient in bed for three months. Eight days after injection of 600 grm. patient walks around; complete cure after three months. (5). Alcoholism, typhus exanthematicus, decubitus, pulmonary affection, 400 grm., injected, cure.—*L'Union Medicale*.—*Maryland Med. Journal*.

#### Treatment of Cerebro-Spinal Meningitis.

Prof. H. C. WOOD, in a clinical lecture in the *Med. Gaz.*, sums up as follows: During the first three or four days in the strong and robust, leeches or cups may be applied to the temples or nape and upper part of the spine. Ice-bags are applied to the head and back of neck for the first days—in many for a week. To relieve headache, restlessness and delirium bromide of potash is the best agent, gr. 20 to 30 every three hours. Its efficacy is increased by adding chloral (ten grain doses usually) or in those who cannot take chloral, tinct. hyoscyami (drachm doses). It is advantageous to add also tincture of castor (drachm doses) in the hysterically inclined. If possible don't use opium, but sometimes it becomes necessary, as the remedies already named occasionally fail. The temperature is not apt to run over 104° (a very harmless height) in adults except at the close, and quinine is not indicated; moreover, it has no effect in lowering the temperature in this particular disease. The best way to lower temperature, if this be an object, is by cold affusions, cold and tepid baths, or the cold pack.—*Ibid*.

#### Turpentine in Diphtheria.

A German apothecary, R. NÜMCH, of good reputation among those who know him, reports that in the case of his own

seven-year-old daughter a teaspoonful, night and morning, of oleum terebinthinæ purificatum, effected a cure of diphtheria. Others who have observed the action of the drug report that its effects are wonderful, a bright redness beginning to spread from the margin of the exudation within half an hour after its administration, and, becoming generally diffused, takes the place of the false membrane in twenty-four hours. Although its effects are most marked early in the disease, it is said to be also valuable, although acting less quickly, after several days have elapsed. It may be mixed with tepid milk. The dose for an adult is a tablespoonful. The remedy is certainly a simple one, and, tried early in the disease, its employment need not prevent other treatment if it fail.—*Med. Age.*

#### Iron in Diphtheria.

Probably there is no disease which physicians encounter in which a greater number and variety of remedies have been proposed and employed than in diphtheria; and it is a usual thing to assert the invariable utility of specific action of certain medical remedies in the treatment of certain pathological conditions, when every intelligent physician knows the fallacy of such assertions. Though we believe iron, when largely and continuously used, contains an efficacy equal to that of quinia in periodical fevers, we use, with marked success, the following:  $\mathcal{R}$  Tinc. ferri, 3 drachms; glycerine, 2 ounces; quin. sulph., 20 grains; aquæ, 2 ounces. *M. Sig.*: Teaspoonful to a child, four years old, every two hours; give according to age. Give Epsom salts freely, to keep the bowels open.

Local treatment:  $\mathcal{R}$  Potass. chlor., 3 drachms; cupri, 3 drachms; acid carbol., 2 drachms; tinct. opii, 2

drachms; glycerine, 2 ounces; aquæ, 1 ounce. *M. Sig.*: Apply with swab or brush every two hours; no water directly after.—*Med. Brief.*

#### To Disguise the Taste of Quinine.

Mr. J. K. LILLY proposes for this purpose a syrup of Yerba Santa, the formula for which he gives in the *Chicago Med. Review*: "Fluid extract yerba santa, four parts; water, eight parts; powdered pumice, one part; granulated sugar, fourteen parts. Mix the fluid extract with the water, evaporate to seven parts, shake with pumice, allow to stand, decant, add sufficient water to preserve measure, then with heat dissolve the sugar. The addition of fluid extract of licorice in the proportion of half a drachm to the ounce of syrup, or of aromatics, adds somewhat to the elegance of the preparation."

#### Influence of Fowler's Solution upon the Hæmoglobin in the Blood.

From an investigation made to determine the effects of the medicinal administration of some remedies upon the proportion of hæmoglobin in the blood, Dr. FENOGLIO, of Turin, concludes that the iron preparations vary considerably in their effects; Fowler's solution increases the hæmoglobin, and this becomes more marked the longer it is given. In spite of the general opinion to the contrary, the administration of Fowler's solution is indicated in anæmia, chlorosis, and in general in all conditions in which there is a decrease in the hæmoglobin, for the influence of this agent is very evident in increasing the proportion of the hæmoglobin; and, furthermore, its use increases the appetite and produces a general improvement in the bodily appearance and condition.—*Medizin. Jahrbücher.—Medical Times.*

DISEASES OF THE NERVOUS SYSTEM.

Fissura Basi-Lateralis.

The *Fissura Basi-Lateralis*, or Fissure of Sylvius, is the great or principal sulcus of the cerebral hemisphere. It differs from all the others in its mode of formation, besides being the first one to begin making its appearance, although not completed until after others are formed. It also differs from the others, when fully formed, in being simply the space between the folded extremities of the hemisphere and the descended operculum. This space is bounded in front by the anterior extremity of the hemisphere (frontal lobe) below by the posterior extremity (temporo-sphenoidal lobe) above by the superior central portion of the hemisphere (parietal lobe and back part of frontal lobe), and internally by the inferior central portion (insular—of Reil).

Towards the end of the third, or the beginning of the fourth, month of intrauterine life, the primitive cerebral hemisphere is more or less ovoid in shape (diagrammatically shown in Fig. 1). It may be divided into four parts; as follows: An *anterior extremity* (ae), a *posterior extremity* (pe), a *superior external, or superficial central portion* (scp), and an *inferior, internal, or deep portion* (icp). Soon after this time the hemisphere begins to bend upon itself in consequence of its extremities dropping below the general axis and the increased growth in an upward direction of its superior convexity (Fig. 2). A double indentation then naturally follows at 1 and 2 of the lower margin. The former is to be the anterior or short limb of the basi-lateral fissure, while the latter develops into the longer posterior

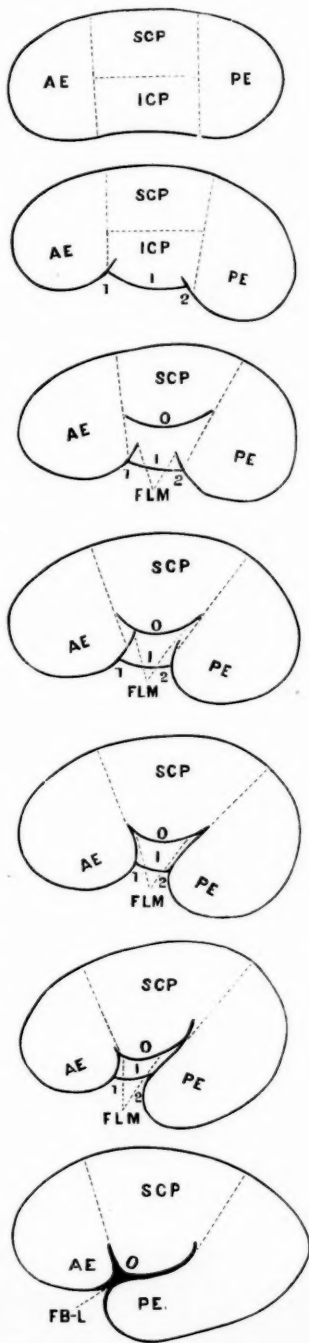


Fig. 1.—A diagrammatic representation of the primitive left cerebral hemisphere divided into four parts: ae—*anterior extremity*; pe—*posterior extremity*; scp—*superior central portion*; icp—*inferior central portion*.

Fig. 2.—Same as above. 1—beginning of anterior branch of the basi-lateral fissure; 2—same of posterior branch of same; i—the lobulus centralis or insula, the same as icp.

Fig. 3.—Same as above. O—operculum, the same as scp. flm, with dotted lines—fossa lateralis magna.

Figs. 4, 5 and 6.—Are progressive changes of the foregoing in the process of evolution.

Fig. 7.—This represents the formation of the fissura basi-lateralis as completed—fb-l. Only three of the four original parts remain in sight, the inferior central portion having disappeared from view to form the lobus centralis, or insula, at the bottom of the fissura basi-lateralis.

limb. The intervening portion (inferior central portion), marked *i*, is to be the insular or lobulous centralis. A little later a horizontal curvelinial indentation appears at the junction of the superior and inferior central portions with its convexity directed downwards; that is, the superior central portion begins to overlap the inferior central portion. This is the beginning of, or the primitive, operculum (*o*). The operculum, then, is derived from the lower part of the superior central portion, while the inferior central portion becomes the insula or lobulous centralis.

As the hemisphere increases in size the development of its posterior extremity progresses much more rapidly than the anterior, so that it gradually curves downwards and forwards under the inferior central portion, and also upwards and forwards over its external aspect, and in this manner meets the hinder part of the inferior margin of the descending operculum to form the posterior arm of the basi-lateral fissure. In like manner does the anterior extremity grow downwards and then backwards, upwards and outwards, to pass inferior and external to the fore part of the inferior central portion, thus covering it; and also upwards to join the anterior part of the opercular margin in the formation of the short arm of the basi-lateral fissure.

When the anterior and posterior extremities have blended with the superior central portion in such a manner as to form a more or less continuous elevated margin, bounding the inferior central portion in front, above and behind, a hollow is formed, the floor of which is the inferior central portion, or insula, and this hollow is termed the fossa of Sylvius, or, as would be more scientific, the *fossa lateralis magna*. This fossa lateralis magna becomes smaller and

smaller as its three boundaries grow over the lobulus centralis (inferior central portion) and eventually it is obliterated, *i. e.*, completely closed, and only the fissura basi-lateralis, composed of its two arms, is left between the anterior extremity of the hemisphere in front, the posterior extremity below, and the operculum above.

Thus, at the end of development, those parts, which at first were the anterior and posterior extremities, eventually become inferior and contiguous. That, also, which at first was the superior central portion (the operculum), at the end is the most inferior of the visible central exterior of the hemisphere. The inferior central portion, or central lobule, is then the only one of the four external hemispherical segments that remains comparatively stationary. The other three grow over and cover it. This gradual covering of the inferior central portion, however, is not due so much to the positive growth of the other three portions facing each other as to a rapid and very disproportionate growth of the superior convexity of the hemisphere forwards, outwards and backwards (especially the latter), so that the anterior and posterior extremities are really *pushed* towards each other along the inferior and outer side of the inferior central portion, while the superior central portion is pushed down and out over the comparatively stationary inferior central portion to meet the anterior and posterior extremities.

#### Hebephrenia.

Dr. FRIC, of Würzburg, considers that hebephrenia occupies in cerebromental pathology as legitimate a place as general paralysis. Its symptomatology is clear and well defined, and the prognosis can be established with certainty from the outset. This affection is tributary to

psychic degeneration, by which is understood an early arrest of development of the brain, in virtue of which the intelligence does not attain its proper development, and at the period of puberty undergoes a regressive evolution. The truth of this statement can be deduced from the proteiform character of the delusions which occur, and from the incoherence of the ideas and acts, which are impulsive and instinctive—depression alternating with exaltation, and complete remissions unexpectedly supervening, followed by rapid relapses. Hebeephrenia—and this has not escaped the notice of Morel—is a psychosis of degeneration, a congenital defect which remains latent during childhood and the early period of puberty, showing itself when the subjects are affected by the inexorable exigencies of life, or are called upon to make intellectual efforts of which they are incapable. Moral insanity cannot be mistaken for hebeephrenia beyond its characteristic symptomatology; it remains stationary for a long series of years, while in hebeephrenia the intellectual loss is precocious. In hebeephrenia the delusions are absurd and unreasonable, like those in general paralysis, and this character, which is an attribute of dementia, serves to distinguish them from systematized delusions. It is possible to confound hebeephrenia with *folie circulaire*, such as has been described by Falret, but it is to be remarked that in *folie circulaire* the courses of mania and melancholia do not exclude a certain degree of lucidity which never occurs in hebeephrenia, on account of the dementia; and the complete remissions observed in the latter never occur in the former. From the point of view of frequency, it can be affirmed—a neuropathic or psychopathic predisposition being admitted—that hebeephrenia is that form of cerebro-mental disease

which most frequently makes its appearance during adolescence. This fact is, however, only verified as regards men. Among females hysterical insanity is its equivalent. Katatonía and hebeephrenia have so many points in common that it is often difficult, if not impossible, to distinguish them, for the spasmodic or cataleptic condition met with in the former is also often present in the latter, and one form may succeed another. In katatonía, however, recovery often ensues; hebeephrenia, on the contrary, is absolutely incurable.—*Dublin Journal of Medical Science.—Med. Record.*

#### The Anæsthetic Action of Styroné.

Dr. S. A. POPOFF has made experiments with styroné, a substance first described by Dr. Beach (*Boston Medical and Surgical Journal*), and obtained from storax and balsam of Peru. Aside from its powerful antiseptic properties, he found the following in experimenting upon frogs and dogs: 1. Hypodermic injections of one milligramme in frogs caused complete anæsthesia dependent on paralysis of sensory nerves. 2. A large dose caused convulsions followed by motor paralysis. 3. The intravenous injection of five to eight centigrammes per kilogramme of weight in dogs caused also anæsthesia. The drug was found to depress the respiratory centre and at times the temperature.—*Mediz. Obozr.—Ibid.*

#### Hysteria.

The *Medical Press and Circular* says that a young girl, aged twenty, was found one night by the police, in an insensible state, lying on one of the benches of the boulevards in Paris. She was removed to the hospital, where she lay for several days in a sort of stupor, taking no nourishment and paying no

attention to anything around her. Before waking out of her lethargy she gave birth, unconsciously, as she afterwards affirmed, to a child. Pins and needles were thrust through her legs and arms, but she gave no signs of sensation. All conceivable efforts to rouse her failed. When finally she roused up, she said that she did not remember anything that had occurred, and was surprised to find herself in the hospital, as she was alone in Paris, her parents residing in the country. The daily papers were much excited, and called her the "fasting girl," but the verdict will not fail to be hysteria.—*Med. and Surg. Reporter*.

#### Physiological Action of the Bromide of Conium.

The *Medical News* says that PREVOST (*Arch. de Physiol.*) comes to the following conclusions from an experimental study of this drug: 1. Paralysis from the bromide of conium results from its effects upon the motor nerves, whose irritability is destroyed. 2. If the blood vessels of the posterior extremities of a frog be tied, and then the drug injected, these parts will remain unparalyzed, while the anterior part of the body is affected. 3. In this way the action of both strychnia and conium can be demonstrated on the same animal. 4. The vagus is affected more quickly than the other nerves, and also regains its normal condition sooner. 5. The secretion of the urine, saliva and tears is increased by conium. 6. The conium is excreted in the urine. The urine of a cat which had been poisoned with conium was evaporated to a syrup, and portions of this were injected under the skin of several frogs, in all of which it produced characteristic symptoms of conium poisoning. 7. The secretory nerves preserve their irritability and augment the

secretions, simultaneously with the loss of irritability of the vagus and muscular nerves. However, electrical irritation of the cervical sympathetic and of the chorda tympani arrests the secretion of the saliva. Peripheral irritation of the nerves of the arm induces free perspiration of the palm, when muscular contraction cannot be produced. The same is true of the nerves of the foot. 8. In the warm-blooded animals, if artificial respiration be resorted to, the heart continues to beat. 9. It is doubtful if the nerve centres are at all affected by the poison, for in warm-blooded animals the convulsions were wholly due to asphyxia, and were relieved when artificial respiration was practiced. 10. The irritability of the muscular substance is not affected by the drug.—*Ibid.*

#### The Medical Treatment of Obstinate Neuralgia.

M. VERNEUIL, in a communication to the Surgical Society of Paris (*Le Prog. Méd.*, No. 49, 1882), referring to the surgical treatment of obstinate neuralgia, said that all therapeutic resources should be exhausted before surgical interference was undertaken. He recalled a case which was cured by hyoscyamin, after resection of all the ends of nerves and even amputation had failed to give relief.—*Med. Record*.

#### DIGESTIVE TRACT.

##### Sulpho-Carbolate of Sodium in Vomiting.

The use of the sulpho-carbolate of sodium, in flatulent dyspepsia is well known. It is not, perhaps, so generally known as a remedy for the vomiting of pregnancy. I have used it in this affection for years, and find it rarely fails to give some relief. I give it in doses of seven grains in half an ounce of water.

Though sometimes decidedly useful in the vomiting of displaced or abnormal conditions of the uterus, it is less uniformly so than in pregnancy, probably because flatulence is a less constant factor in the former cases. Where deep nerve disturbance exists, we must trust to more powerful remedies, hypodermic morphia or atropine, or surgical procedures. The drug will perhaps, be useful against sea-sickness, taken every two hours from the time of sailing. In one case—the only one tried—it appeared to have a good effect.—Philip Miall, in *Brit. Med. Journal*.

#### Intestinal Obstruction

Caused by an accumulation of faecal matter is relieved by Dr. J. FOSTER BUSH (*Boston Med. and Surg. Journal*) by means of the rectal tube. The one which he employs "is the red-rubber stomach tube made by the Davidson Manufacturing Company, which is twenty inches long, with an external surface as smooth as glass." It causes little or no pain in its introduction, and delivers the fluid high up in the bowel.—*Weekly Med. Review*.

#### Painful Swelling of the Liver in Young Alcoholic Subjects.

MATHIEU considers the tender enlarged liver in young alcoholic subjects as due to chronic congestion, and believes that this is an important feature in diagnosis, especially when taken in connection with other symptoms of alcoholism. It is considered as a premonitory sign of interstitial inflammation in the liver, and therefore of importance in prognosis and in the indications for treatment.—*La France Medicale*.—*Med. Times*.

#### A Cholagogue Formula.

Dr. BLACKWOOD publishes in the *Medical Times*, Philadelphia, the follow-

ing formula, which he has found very serviceable in many a stubborn case of dyspepsia that had run the gauntlet unavailingly of all sorts of peptonoids. It is also, he says, an admirable cholagogue on general principles. It is certainly correctly based on the physiological action of its base and adjuvants as demonstrated by the experiments of Rutherford:  $\mathcal{R}$  Cinchonidiae sulphatis, eunommin, leptandrin, iridin, juglandin,  $\text{ää}$  3 ss.; podophyllin, ext. belladonnae, ext. nucis vomicae, ext. hyoscyami,  $\text{ää}$  gr. x. M. ft. mass. et div. in pil. no. lx. Sig.: One or two at bed time.—*Med. Age*.

#### Mineral Acids in Summer Diarrhoea.

The mineral acids are very efficient in sporadic cholera and summer diarrhoea. The indications for their use are the profuse and watery characters of the discharges, which are alkaline or neutral in reaction, due to outward osmosis from the serum of the blood, and the best of the acids is sulphuric acid given with opium. Hope's camphor mixture is also frequently used, especially in the pulmonary diarrhoea with benefit.—*Bartholow*.—*Col. and Clin. Record*.

#### Notes from Cases in Practice.

Dr. J. B. R. PURNELL (*Maryland Med. Journal*).—ALOES.—This useful medicine will not cause hemorrhoids, as stated by some authors. It often tends to alleviate or cure that disease when properly combined with an alkali, as soda bicarb. or lithia carbonate. It will act on the upper as well as lower intestines, notwithstanding the contrary statement in some of the works. To prevent any unpleasant effect, add alkali and a little aromatic, and, when requisite, hyoscyamus extract. Aloin, the active principle of aloes, is effective in

1-4 or 1-5 the quantity of that substance, and I am confident it is the best cathartic ever discovered when properly prepared, even as a cholagogue excelling hydrarg. chlor. mite in the great majority of cases. It should have a deep yellow color, also an intensely bitter taste, which, however, can be disguised with extract glycyrrh. and soda bicarbonate.

A short time before his decease, Gov. Henry A. Wise said to the writer, "You doctors say aloes will produce piles, but I tell you it will cure them." I, in substance, replied that his statement accorded with my own experience.

**SUGAR IN DYSPEPSIA.**—I have for many years been using pure sugar in some forms of dyspepsia. Though often beneficial when employed *alone* either in sick headache or in migraine attended with vomiting or nausea or a tendency thereto, the following combinations will in some cases be found of great value :  $\mathcal{R}$  Sacch. albi,  $\mathfrak{z}$  i-ij. ; zingiberis, gr. v. ; sodii chlor., gr. v-x. M.  $\mathcal{R}$  Sacch. alb.,  $\mathfrak{z}$  i-ij. ; capsici, gr. iij.-vi. M. S. : To be taken alone or with but little water.

#### Atrophy of Gastric Glands a Cause of Pernicious Anæmia.

In an article entitled "Bijdrage tot de Studie der Progressive Perniceuze Anæmie" (*Weekblad van het Neder. Tijdschrift voor Geneeskunde*), Dr. W. NOLEN communicates the clinical history of two cases of this disease in which the post mortem examinations revealed interstitial inflammation of the mucuous membrane of the stomach, with partial or total atrophy of the gastric glands. The aemia appeared as the result of the stomach affection.—*Centralblatt für Med. Wissen.*

#### DISEASES OF THE URINARY ORGANS.

##### Nocturnal Eneuresis, Treated by Voltaic Alternatives.

Dr. ALTHAUS writes in the *British Medical Journal*: In June, 1882, I was consulted in the case of a boy, aged 15, who had suffered from incontinence of urine during sleep, ever since he was nine years of age. He had been treated with belladonna and other medicines without relief ; and as he was about to enter a public school, where a continuance of this trouble might have been particularly annoying, the parents were very anxious that something more should be done. The boy's general health was good, but he was considered a nervous child, and highly sensitive. There were no ascarides, but he had a very long prepuce which could only with difficulty be retracted. There was, however, no suspicion of masturbation. Treatment by electricity having been recommended, I applied the middle-sized circular cathode over the region of the bladder, and the large oblong anode (five inches by two) to the lumbar portion of the spine. The current strength 2.50 milli-ampère for five minutes at a time. As after a few such applications no material benefit appeared to have been gained, I then added fifty voltaic alternatives produced in the metallic circuit. The night after this was free from the usual annoyance, and the boy has made an apparently uninterrupted recovery. Dr. Althaus prefers this method of treatment to injections of nitrate of silver, as recommended by Sir Henry Thompson. He believes that belladonna is of value when eneuresis is distinctly caused by undue excitability of the bladder.—*Med. & Surg. Reporter.*

##### Diabetic Coma.

Drs. FOSTER and SAUNDBY record a carefully studied case of diabetic coma in the *Birmingham Medical Review*.

They have summarized their conclusions as follows: 1. Diabetic coma is especially liable to supervene in acute cases in young persons. 2. Diabetic patients and their friends should be warned of the danger of constipation, muscular exertion, nervous excitement, and cold, as probably predisposing causes of death by coma. 3. The discovery of the ferric chloride reaction in the urine should be taken as a warning to look out for the premonitory symptoms of coma. 4. Deep respiration, rapid pulse, and abdominal pain are the earliest premonitory signs of this condition. 5. Cyanosis may be absent in spite of the dyspnoea, and may appear only just before death. 6. Convulsive seizures are not an uncommon occurrence just before death. 7. Diabetic coma, with all its classical symptoms, occurs independently of any excess of fat in the blood, and the pathological value of lipæmia, when present, is yet undetermined. 8. The toxæmic theory, or poisoning by acetone or some nearly allied substance or substances, affords the best explanation of this remarkable group of symptoms.—*Weekly Med. Rev.*

#### **The Bromide of Arsenic in Diabetes.**

Dr. BÉKAI, of Buda-Pesth, reports two cases of diabetes in which Clemens' liquor arsenici bromati was used. In the first case, after eleven days' use of the drug, together with an animal diet, the sugar disappeared from the urine. Upon leaving off the treatment, one per cent. of sugar appeared again, but disappeared upon renewal of treatment. In the second case the results were not quite so good.—*Wiener Med. Blätter.*

#### **DISEASES OF THE CIRCULATORY ORGANS.**

##### **Intercurrent Pleurisy in Heart Disease.**

Dr. BUCQUOY has observed a number of cases of pleurisy occurring in the

course of heart disease. He states that notwithstanding the weakened condition of the patients consequent upon the prolonged cardiac trouble frequently associated with albuminuria, the inflammation presents all the characteristics of subacute idiopathic pleurisy, and is entirely distinct from hydrothorax. It usually pursues a favorable course, ending after a variable duration in a cure with resorption of the effusion. The treatment should be that followed in ordinary pleurisy. It is, however, desirable that a cure be obtained as speedily as possible, because of the embarrassment of the already enfeebled heart by the pleuritic effusion. Consequently the author advises an early thoracentesis in all cases in which the absorption of the fluid is delayed. Especially should this be done if dyspnoea or other urgent cardiac symptoms be present.—*La France Médicale.*—*Ibid.*

##### **Some Points in the Treatment of Cardiac Disease.**

From a number of carefully-studied cases of heart disease, Dr. FINNY (*Dublin Journal of Medical Science*) draws the following conclusions: 1. That too much dependence is not to be placed on the presence of the physical signs of mitral regurgitation as evidence of organic disease. 2. That such signs may be due to purely functional derangement and weakness of the heart, or to an altered condition of the blood. 3. That blood-murmurs produced in the heart and large vessels may be louder than the murmurs due to valvular lesions. 4. That the danger of valvular diseases is enormously increased by, if not directly due to, weakness of the cardiac walls. 5. That increased action and force of the ventricular contraction in the presence of valvular disease is not to be considered a disease, but rather a symptom of disease, and is directly propor-

tionate to the amount of regurgitation or obstruction 6. That mitral regurgitation is not to be considered in the light of a "safety-valve function" in cases of aortic obstruction, but as an element of increased danger to life. 7. That lowering treatment of the heart's force is rarely, if ever, required in disease of the organ. 8. That indications for treatment in diseases of the heart should be sought from the evidence of the condition of the muscle of the heart, and not that of the valves.—*Med. Record.*

#### **Pulsation of Spleen in Aortic Incompetence.**

The *Medical Times and Gazette* says it would appear that this sign of aortic incompetence has not been previously described. Attention has now been drawn to it by Dr. GERHARDT, in the *Zeits. für klin. Med.*, IV., S. 449, without any attempt being made to magnify the importance of the phenomenon. We are familiar with pulsation in the smallest vessels of many of the visible parts of the body in aortic incompetence, including the bed of the nails; and Quincke has shown how the two factors necessary for its production are, relaxation of the vascular walls, and sudden great variation in the blood-pressure, such as occurs in aortic regurgitation. In Gerhardt's three cases the spleen was large and the patients in high fever. The splenic tumor swelled during cardiac systole, expanding gradually, and diminished in size again during diastole. A dull double sound was audible over the tumor, apparently distinct from the cardiac murmurs, which could be made out at the upper part of the tumor. To the finger the pulsation had not the characters of an aneurism, but was of the nature of a soft swelling, very much as in pulsating jugulars. The sign appears to be not

entirely without some prognostic value, inasmuch as it indicates a sound condition of the left ventricular walls, and compensation, as far as possible, of the valvular inadequacy—*Med. & Surg. Reporter.*

### **DISEASES OF RESPIRATORY ORGANS.**

#### **The Treatment of Pneumonia.**

We are indebted to Dr. W. THORNTON PARKER, Acting Assistant-Surgeon, United States Army, Fort Elliot, Texas, for the following item, communicated to him in a private letter by Prof. Baumler, of the University of Freiburg, Baden: "Our treatment in cases of pneumonia in the Freiburg Hospital is chiefly directed toward sustaining the strength of the patient until in the natural course of the disease the pyrexia leaves him. As the pyrexia is one of the chief causes of the exhaustion which in severe cases gradually sets in, we try to keep down the body heat by means of cool baths or wet packing, as well as by quinine (fifteen to twenty grains in one dose in the evening) or salicylate of soda (sixty to eighty grains within an hour in the middle of the night). The patient must be sufficiently fed by broths, beef tea and milk, and in every case we give from one-half to one pint of light wine, to which the populace is accustomed, in the twenty-four hours. *An ice-bag is applied to the chest when there are pleuritic pains.* Dover's powder or morphia is only given when there is restlessness or great pain or diarrhœa. With very sharp pains in the side we apply the morphine hypodermically. If there be much bronchial catarrh accompanying the pneumonia, we give ipecacuanhæ in infusion with or without opiates. Sweet spirits of nitre I have never employed in pneumonia. Altogether, it is but very seldom used in Germany."—*Ibid.*

# CONSTITUTIONAL DISEASES.

## The Albuminuria of Fevers.

Dr. ECKSTEIN distinguishes three varieties of albuminuria accompanying the febrile state (*Deutsche Medizinische Wochenschrift*): First, albuminuria caused by acute nephritis; second, the so-called febrile albuminuria; and third, albuminuria caused by venous hyperæmia. The last form, in which the urine is small in quantity and of high specific gravity, occasionally containing casts and renal epithelium, is diagnosed mainly by the presence of other symptoms pointing to venous hyperæmia, such as cyanosis, enlargement of the liver, and dyspnœa. The author opposes the belief that venous hyperæmia is the sole cause of albuminuria in febrile disease. He believes that it is responsible for the albuminuria occurring in acute croupous pneumonia, and in rapidly formed pleuritic effusion, the local affection acting mechanically, first on the right side of the heart, then on the venous system generally. Acute nephritis Dr. Eckstein believes to be a metastatic inflammation, an infective process, in which the microorganism, although it has not yet been demonstrated, as in kidney affection from diphtheria or pyæmia, will at no distant date be isolated. The result of acute nephritis is either complete recovery or death, very rarely chronic nephritis.

In the so-called febrile albuminuria, which Dr. Eckstein mainly considers, the amount of urine is but slightly diminished, according to the severity of the fever itself; the amount of albumen is moderate, and the normal excretory constituents of the urine are not diminished. That the albuminuria in such cases is caused by hyperæmia of the kidney, either active or passive, seems

to Dr. Eckstein improbable. For the first result of a congestive hyperæmia would be an increased amount of urine which is not present; and on the other hand, there is no reason to suppose a passive hyperæmia, except in such cases as have already been classed under albuminuria from direct venous congestion. Runeberg has lately explained the diminished secretion and albuminuria in febrile diseases by the degeneration of the heart-muscle and consequent fall of arterial tension. But, as Dr. Eckstein points out, in many diseases where the arterial tension is reduced to a very low point, there may be absolutely no albumen in the urine. That the albuminuria is caused simply by the abnormal temperature, or by an alteration of the albumen of the blood, is not, Dr. Eckstein believes, supported by fact. For the albuminuria is frequently in no relation whatever to the temperature, and the albumen in the great majority of instances in no way differs from the serum albumen of the blood.

Dr. Eckstein sums up his views as follows: Febrile albuminuria depends on a local process in the kidneys of an inflammatory nature, or at least closely related to inflammation, and having its site mainly in the epithelium of the kidney, cloudy swelling, albuminous infiltration, or parenchymatous inflammation. This process is probably caused by an infection of the kidneys, either from the passage through them of low parasitic organisms, or from the inflammatory action of soluble toxic substances passing through them. The same infection acting in a stronger degree can produce acute nephritis. Acute infective nephritis, therefore, and febrile renal affection, are only different degrees of the same process, or, in other words, the febrile renal affection is an aborted acute infective nephritis.

### Faradization of Spleen in Intermittent Fever.

The *London Medical Record* says that Dr. BABATIEFF regards (*Mediz. Obozr.*) systematic faradization of the spleen as one of the best adjuvant means in the treatment of intermittent fever, and adduces some cases of his own in which the usual antiperiodic remedies had remained unsuccessful until the electricity had been added. The faradization not only diminished the splenic tumor, but also acted beneficially on the malarial process. This favorable influence the author attempts to explain as follows:

1. Faradization gives rise to contractions of the splenic vessels, and, in a reflex way, acts tonically on the vaso-motor centres.
2. It counteracts blood-stagnation, and possibly accumulation of miasmatic products in the spleen.
3. It acts indirectly on the neighboring kidney, increasing correspondingly the secretion of urine.
4. It prevents the formation of infarcts and ruptures in the spleen.

The editor of the *Mediz. Obozr.*, Dr. V. F. Sprimon, also testifies to the high value of faradization and galvanization in cases of chronic malarial tumor of the spleen. He saw its prompt disappearance, as well as a great improvement of the general state, in four out of five of his patients treated by this method. In four of the eight of Dr. Sprimon's cases which presented intermittent of recent standing, and were treated by faridization alone, the fever disappeared and never returned after five to ten sittings (half an hour daily).—*Med. and Surg. Reporter.*

### Intermittent Spinal Paralysis.

Generally speaking, malaria causes far more frequently affections of other parts of the human organism than such of the nervous system, if we except neu-

ralgias. That, however, sometimes the nervous centres suffer severely, and especially the spinal cord, has also been attested to by many cases on record. Very interesting is the following case which Dr. V. O. GIBNEY publishes in the *Jour. of Neurol and Psych.*: Five times a boy, seven years old, was attacked by diffuse paralysis due to malaria, and especially of the lower extremities. Each time an energetic treatment with quinine and removal out of the affected locality induced a cure. The electric excitability of the emaciated and paralyzed muscles was greatly diminished; typical reaction of degeneration was, however, wanting. In a second case, a boy æt. six, had twice similar seizures. Dr. Gibney supposes that congestion of the spinal marrow, first active and later passive, hyperæmia accompanied by œdema, form the pathological-anatomical basis for these paralyses. The cord, surely, is not affected organically, otherwise the cure due to quinine would not be so effective and radical.—*Ibid.*

### Jaccoud on the Treatment of Typhoid Fever.

In the prolonged discussion of the subject of the treatment of typhoid fever before the Académie de Médecine, the parasiticide theory and treatment based upon it were vigorously opposed by JACCOUD, who also gave a rapid *résumé* of his method of treatment which he had employed for sixteen years, and from which he claimed to have had such success as to reduce the ordinary mortality rate of 19 per cent. down to 10.83 per cent. He based his treatment upon two characteristics of the disease—first, the adynamia; secondly, the abnormal calorification. From these result two great therapeutical indications—first, to

spare and sustain the forces of the patient from the beginning; secondly, to remove a portion of the heat produced, and to restrain the heat-production. These indications are filled by a systematic method of treatment instituted as soon as the diagnosis is made. It comprises two parts—first, alimentation with broths, wine, and especially milk, in the quantity of one or two litres per day; and, secondly, by the use of alcohol, which is administered in the dose of 30 to 80 gm. daily in punch, taken by spoonfuls. To this alcoholic drink Jaccoud adds extract of cinchona; this is continued during the entire duration of the fever. In this manner he seeks to fulfil the first indication to correct the adynamia, and also, through the use of the alcohol, to diminish slightly the combustion of the tissues and the production of heat.

From the beginning he also seeks to reduce abnormal heat by having the body sponged off with aromatic vinegar and cold water from four to eight times daily. Should the temperature continue as high as 40° (104° F.) for several days in spite of the sponge-baths, he resorts to antipyretic agents, such as bromhydrate of quinia and salicylic acid, the doses being the same. The first day he gives no more than 2 gm. at the most, taken in one dose, either in the morning or in the evening. The next day he reduces the dose by .50 gm., and on the day following .50 gm. more of the remedy is continued so long. He allows the patient to rest after the second or third dose for at least forty-eight hours, and then he recommences.

On account of the antiseptic qualities of salicylic acid, he gives it the preference, except in the presence of the following contra-indications: First, alcoholism; second, violent cerebral symptoms; third, feebleness of the heart;

fourth, symptoms of renal disorder. But these conditions are not contra-indications to the use of the quinia salts, nor would they interfere with their employment. In case pulmonary congestion should occur, dry cups are used to the number of thirty or forty per day.

In conclusion, Jaccoud protested against overdosing, and paid his respects to the bacteriophobists who treat typhoid fever on the theory that it is a parasitic disease, this leading them to an immense abuse of salicylic acid, phenic acid, etc., without concerning themselves regarding the tolerance of the individual. He said that "the result is that in striking at the microbe they knock down the patient. Even when it shall be shown that the fever is caused by a bacterium, the physician ought never to lose sight of the human being whom he has under his charge: he should take into consideration the individual constitution of the patient, his powers of resistance, and the effects which the means employed may produce upon him; if not, he will be the victim. One cannot guard himself too much against these sudden storms or hurricanes of fashion in therapeutics."—*Bulletin de l' Acad.—Med. Times.*

#### Antiseptics in Typhoid Fever.

Dr. GALLOIS, in a communication to the *Journal de Médecine*, relates his experience in the use of antiseptics in typhoid fever. For the past five years he has employed in typhoid fever rectal injections of phenic acid, and has never observed any toxic effect. In benign cases it is his custom to order an injection each morning, to which is added from ten to twelve drops of phenic acid dissolved in alcohol. In graver cases he advises a second injection in the evening. These injections have always

been well borne. He admits the antipyretic action of the drug, but employs it for its antiseptic action. He also employs, in cases where the fever is high, sulphate of quinine. This note of Dr. Gallois' shows that the use of antiseptics in typhoid fever is not entirely new. He claims an exceedingly low rate of mortality.—*Weekly Med. Review.*

#### Previous Symptoms in Typhoid Pointing to Perforation.

In a communication by Dr. BYERS before the British Medical Association several cases are reported of death from perforation from typhoid ulceration of the small intestine. The following clinical features are believed to indicate the appearance of this serious accident :

1. The gravity of the case. Perforation is met with most frequently in the more serious cases of the disease. Liebermeister and Murchison both agree in this: the latter states that "in a large proportion of cases of perforation the previous symptoms are severe, and diarrhœa, as might be expected, is a prominent symptom. This was the case in sixty out of sixty-nine of my patients. In eleven of the sixty the symptoms of the peritonitis were preceded by considerable intestinal hæmorrhage, and in many there was an unusual amount of abdominal pain.

2. As regards great tympanites, Sir W. Jenner says: "A single deep slough-formed ulcer will paralyze the action of the bowel and lead to such an accumulation of flatus as produces enormous distention of the abdomen." It is just in such a case that perforation would be likely to occur.

3. Continued elevation of temperature after the third week, in the absence of any complication, usually points to severe intestinal lesion.

4. As to constipation, Sir William Jenner has pointed out that "a single deep ulcer will paralyze the action of the bowel, and so cause constipation."

5. Another symptom is severe tremor.

6. Protracted headache in the early stages is believed by Dr. Broadbent to denote an unusually severe affection of Peyer's patches.

7. Dr. Cayley has directed attention to the value of *tache cérébrale* in enteric fever. He says it often lasts for some time after convalescence has set in, and he regards its persistence as an indication that the intestinal ulcers have not yet healed, and that therefore the patient is still liable to relapses and to the complications attending unhealed ulcers.—*Med. Times.*

#### Revival of Blood-Letting as a Therapeutic Resource.

In the Paris letter to the *Lancet*, the views of two of the most prominent practitioners of that city with regard to blood-letting are referred to as follows: "Professor Peter, who was one of Trousseau's most fervent disciples, and present editor of his clinical work, employs venesection on rather a large scale, particularly in cases of apoplexy and epilepsy, in which Professor Trousseau condemned it altogether. At his clinical meetings, and in his lectures at the School of Medicine, Professor Peter teaches that, with all deference to his former master, he has found by experience that blood-letting, if judiciously employed, is invaluable in some cases, and apoplexy is just one of those in which it would be found useful. As in the days before the publication of Professor Trousseau's clinical works, Professor Peter practices blood-letting at the moment of the attack, with the hope of cutting it short, and he does so at a later stage with the view of facilitating

the reabsorption of the clot of blood formed at the seat of the lesion, and to moderate the congestion in its neighborhood. On the strength of this theory, Professor Peter, at his clinic, lately bled a patient who was upwards of sixty for an attack of apoplexy and hemiplegia of the left side, and he declared, at a meeting of the Medical Society, that this bleeding had been the means of saving the patient from imminent death. He employs general depletion even in the convulsions following apoplexy, with great benefit to the patient, as he had noticed that, notwithstanding the presence of a large quantity of albumen in the urine, the convulsions and the albumen had entirely disappeared after a small bleeding from the arm. Professor Vulpian employs blood-letting in its various forms in all cases of inflammation, and he has found it invaluable in peritonitis, whether from puerperal or other causes. At the Clinique d'Accouchement, Professor Depaul scarcely employs anything else in puerperal convulsions. He bleeds the patients largely and repeatedly until the most urgent symptoms are relieved, and he has frequently stated at the Academy of Medicine and at other medical societies that the results of the practice that he has carried out for more than a quarter of a century can bear comparison with any other method of treatment adopted by other physicians in similar cases: in fact, the mortality among his patients has always been considerably less."—*Med. Times.*

#### The Action of Hot Foot-Baths.

The London *Med. Record* says that Dr. SHOLKOVSKY (*Vratsch*, 1882, No. 7) undertook a series of experiments, in order to elucidate the influence of an ordinary hot water foot bath on temper-

ature and circulation in all remote parts of the body. The experiments (as many as 115) were made mostly on quite healthy subjects, and on few weak and anæmic persons, in the period of convalescence from various acute and chronic affections. The duration of bath varied from fifteen to twenty minutes, and the temperature between 107.6° to 114.5° Fahr.; but, as a rule, the author used a fifteen minutes' bath, at the temperature of 108.5° to 110° Fahr. The water reached nearly up to the knee. He arrived at the following conclusions.

1. Under the influence of a hot foot bath, the temperature in the external auditory meatus gradually rises, reaching its maximum within five minutes after bath. The elevation generally oscillates between 0.1° and 0.3° Reau., but sometimes is as high as 0.5° Reau.
2. The axillary temperature in the vast majority of cases rises also, but less considerably. Its elevation mostly varies between 0.1° and 0.2° Reau., and never goes higher than 0.3° Reau. (one case of 47°).
3. The rectal temperature in the vast majority of cases decreases, reaching its lowest point after bath. The fall is persistent, and generally varies between 0.1° and 0.3°, but sometimes (two cases of 47°) is equal to 0.4° Reau.
4. Plethysmographic measurements of the upper extremity show that the volume of the limb in the first moments of the bath rather decreases, but then begins gradually to increase, reaching its maximum approximately about the mid-time of the bath, and remaining at the maximal height to the end. After the bath, it begins to decrease very slowly.
5. The measurements of the radial tension, taken by means of Basch's sphygmomanometer, show increase of it during the bath, and the next ten or fifteen minutes. The average increase is equal to eight millimètres, maximal to seven-

teen millimètres, minimal to two millimètres. 6. The observations on the character of the pulse wave (in art. brachialis, studied by means of Rothe's and Knoll's apparatus) show that the latter presents all qualities described by Landois, Moens, Bernard, etc., as typical for a wave under high blood pressure (the more round apex, the appearance of dicrotic indentation, and of so-called elastic elevations nearer to the apex, and so on). 7. The number of pulse beats generally increases, the maximum of the increase being 24; the minimum 3; average, 5. After the bath, the acceleration of the pulse disappears rather rapidly (comparatively with all other phenomena produced by the use of hot foot baths).—*Ibid.*

#### Erysipelas

Was formerly looked upon as of two varieties, the idiopathic and the traumatic, but latterly it is considered as having a traumatic origin. Prof. JAMES T. WHITAKER (*Cincinnati Lancet and Clinic*) says that it never occurs without a solution of continuity somewhere in the skin, and that although it may sometimes affect the mucous membranes, the same law holds good here also. Trousseau was the first to advance the idea of its being invariably traumatic. He holds that there must be a predisposition to the disease, and cites Trousseau's attempts to inoculate himself and two of his students without success, while Willan and others succeeded in the experiment. He believes that there is a tendency to the disease in some persons, more particularly those of a scrofulous habit, and while he looks upon ordinary erysipelas as an affection of small moment, he says it may assume the suppurative form, when serious complications may arise, as peritonitis, rheumatism, or parenchymatous nephritis or meningitis.

As to the local treatment of the disease in its primary stage, he recommends the hypodermic injection of a strong solution of carbolic acid in glycerine. Ten or twelve injections may be made, but never more than two in one day. When the temperature is 105°, and there is danger of meningitis, the cold bath is proper. As a precautionary measure, to prevent the infection of others, he suggests that surgeons should never undertake an operation, having previously waited upon an erysipelatous case, without first heating their instruments in a Bunsen's burner, or at least placing them in boiling water before operating.—*Ibid.*

#### White Paint in Erysipelas.

Mr. BARWELL (*Lancet*) has found white paint very efficacious in erysipelas. He reports three cases in which its application was followed by prompt relief of pain and swelling. He mixes carbonate of lead, after the usual manner, with linseed oil, a little turpentine being added as a dryer, and applies freely to the inflamed surface. The remedy probably acts by occlusion of air after the same manner that it does with so much benefit in burns.—*Med. Age.*

#### Erysipelas in the Stomach.

A case in which an attack of facial erysipelas extended to the pharynx and thence into the stomach is reported in *La France Médicale* (No. 75). The symptoms were pain in swallowing food, tenderness in the epigastric region, and obstinate vomiting for five days,—a feature which might be thought to be due to meningitis, but this supposition was promptly removed by the observed fact that there was a complete absence of other cerebral symptoms.—*Med. Times.*

### The Etiology of Diphtheria.

Dr. EDWARD WOAKES gives the following as his conclusions after an extended consideration of the subject :

1. Diphtheria is an idiopathic inflammation, the peculiar type of which is imparted by previous exhaustion of sympathetic nerve-force; that the loss in question occurs chiefly in children, in whom the nutritional centres are normally in special activity, and that this exhaustion acknowledges chiefly climatic conditions possessing in themselves no other peculiarity than is implied in the tendency to lower the vital energy of the subjects exposed to them. The patient so circumstanced may be said to exhibit the diphtheritic diathesis. During its continuance exposure to a slight exciting cause, such as a common cold, will suffice to develop a typical attack of diphtheria. Under these circumstances the disease may be said to arise *de novo*.

2. When the diphtheritic process is established, in whatsoever way it may be brought about, the element of contagium is introduced. Though not, perhaps, yet capable of exact histological identification, this is nevertheless a definite tissue element, forced into rapid growth. In this state it is liable to be thrown off with the detritus of the process, and is capable of continuing its developmental energies, and of exciting a similar action in the corresponding tissues of another subject, if it come in contact with these, providing the subject be already predisposed to exert insufficient inhibitory nerve-power to resist the tissue-demand for such an accession of blood as will suffice to feed the new process to the diphtheritic point. The latter quality resides entirely in the vaso-motor resources of the patient.

3. The explanation of the symptom of sudden death occasionally witnessed in the disease is shown to depend on a similar paresis of the nutrient vessels of the cardiac branches of the vagus as was seen to occasion the local lesions in the throat when affecting the vessels of this area. In consequence of the engorgement of the circulation within the nerve-sheaths, and the jugulation thereby of the contained fibrillæ, the latter are unable to transmit inhibitory impressions to the heart, which accordingly ceases to beat after a continuance of rapid action has exhausted its inherent vitality.—*Lancet*.

### Chloral Hydrate in Diphtheria.

In a report by the *New York Medical Times* of a meeting of the Medical Society of Northern New York, Dr. ALLEN, of Lawyerville, appears as stating that he has found that diphtheritic membrane is speedily dissolved in a solution of chloral hydrate. He employs it in the strength of fifteen grains to the ounce, and applies it at intervals of two or three hours by means of a brush. A stronger solution, say of thirty grains to the ounce, may be employed in adult cases. He says that it is seldom that the densest coating resists the second or third application. There is unfortunately abundant opportunity for testing this statement in this city at the present time. The application is certainly strongly antiseptic and has the advantage of being innocuous.

### Chinolin in Diphtheria.

Excellent results have been described by SEIFERT in the treatment of diphtheria by chinolin (*Berlin. Klin. Wochenschrift*, No. 22). In a series of cases, slight and severe, of diphtheria in adults, and in a smaller number of cases in

children, the only case of death was that of a child a year and a half old, rickety, ill nourished, and the subject of constitutional syphilis. Instead of the unpleasant tartrate of chinolin hitherto used, Seifert prefers a five-per-cent. solution of pure chinolin in equal parts of alcohol and water as a local application, and a one-fifth-per-cent solution in water, with a little spirit and peppermint, as a gargle. The stronger solution was applied with a brush from once to four times daily, and a new brush used for each spot painted, those once used being destroyed by fire. Immediately after the application the patient feels a burning, smarting pain, which is soon removed by a little cold water and gives place to a feeling of great relief, so that swallowing becomes easy, although before it was impossible; the fœtor speedily ceases, the membranes come away in slight cases within twenty-four hours, the glandular swelling quickly subsides, and the temperature rapidly falls to the normal. The only other treatment adopted was an ice cravat in severe cases.—*Lancet*.

#### Rheumatism.

Powdered capsicum as a remedy in sub-acute and chronic rheumatism has been recommended by Mr. A. DRUMMOND MACDONALD in the *British Medical Journal*. Two drachms to the ounce of lard, to which one of the essential oils may be added to make it more elegant, is the proportion mentioned. It is to be thoroughly rubbed over the affected part by a gloved hand for ten minutes at a time night and morning, or at bedtime only, according to the effect produced. Dry heat applied afterwards intensifies its effect, which lasts for some time.—*Weekly Med. Review*.

#### Acute Rheumatism.

Dr. J. B. WALKER, Med. Clinic Philadelphia Hospital (*Med. Times*), presented a case of acute rheumatism which commenced as sub-acute. He laid great stress on the necessity of examining daily the heart in all cases of acute articular rheumatism, because, while *pericardial* trouble may direct attention to the heart by causing pain, *endocardial* inflammation may run its course without offering any pain; and even when it does not, the joint suffering may be so great as to mask it. He believes in combining the salicylic acid and alkaline treatments; the former is curative to the rheumatism, while the latter controls the cardiac complications. There is no antagonism between the two treatments. He uses salicylate of sodium, twenty grains, and bicarbonate, acetate or citrate of sodium, or potassium, twenty grains, every alternate two hours. When joint pains have ceased the salicylates are of no use, but the alkaline treatment should be continued as long as there are evidences of heart trouble. Large hot poultices over the heart are of vast service, but blisters will do no more than merely relieve pain, though a small (2x2) cantharidal blister may immediately precede the poultice. Avoid all exposure and insist on absolute quiet. Salicin is tonic as well as anti-rheumatic, so that it may be substituted for the salicylate when the patient is very weak. Tincture of chloride of iron is very beneficial in convalescence.

#### An Unusual Case of Polydipsia.

A woman aged forty, of hysterical temperament, had been troubled for three years with gurgling, plashing and whirring sounds of confined liquid issuing from the region of her stomach, with such violent action as to irresistibly

jerk and agitate her whole body. All treatment had proved useless, when she came under the notice of Dr. D. D. MARR, of Chesterton, Ind., who reports the case in the *Chicago Med. Jour.* She would drink from one to two gallons of water per day and pass urine in large quantities; sp. gr. 1.008, no sugar. Sub-nitrate of bismuth, in drachm doses, three or four times daily, was the only remedy that gave any relief. She subsequently became pregnant, after a favorable termination of which her condition greatly improved.—*Med. & Surg. Reporter.*

#### A New Reaction of the Urine in Infectious Diseases.

The *Med. News* says that at a recent meeting of the Gesellschaft der Charité-Aerzte, in Berlin, EHRLICH described a new reaction of the urine. When a solution of sulphanilic acid (*sulphanilsäure*) and ammonia is added to the urine from cases of tuberculosis, typhoid or other infectious fever, a bright-red color is produced. The urine from cases of ordinary inflammatory or febrile diseases does not give this reaction. The details are promised.—*Beliner klin. Woch.—Ibid.*

### DISEASES OF THE NERVOUS SYSTEM.

#### Nerve Stretching.

In the *Lancet*, Dr. AUGUSTUS H. BAMPTON describes a case of supra-orbital neuralgia, in which the patient had used all known remedies without any relief, until the supra-orbital branch of the frontal nerve was cut down upon and stretched with a blunt hook, just behind its entrance to the supra-orbital notch. The relief was immediate, the wound healed by first intention, and up to one month after the operation, when

he was discharged, there had been no return. The pain returned at intervals during the following winter, but considering the simplicity of the operation, the author considers that it should always be resorted to when other treatment fails, in this painful affection.—*Med. and Surg. Reporter.*

#### Hypnotism as a Therapeutic Agent.

Prof. ACHILLE DE GIOVANNI, having made use of hypnotism in a number of cases, reports (*Clinica Medica della Università de Padova*, 1882), sufficiently satisfactory results to warrant the extension of this method in practical therapeutics. The following is a *résumé* of the cases published :

1. Rachialgia in a broken-down nervous subject, which had been previously successfully treated by massage for contractures of the lower extremities. The artificial hypnotic condition was readily produced. It was repeated every day for a week, during which period the pain ameliorated and finally disappeared. At the same time the *morale* of the patient greatly improved.

2. A woman, 18 years of age, complained of great pain in one leg and pain in the back ; afterwards vomiting occurred, and persisted once or twice daily, without being more than temporarily improved by treatment. Hypnotism was tried, all other treatment discontinued. At first she could only be put to sleep with difficulty, but on persisting she was more easily influenced ; the vomiting stopped. The cure persisted for at least a month after cessation of the treatment.

3. A nervous woman complained of arthralgia and contracture in the right leg, which improved by application of electricity to the homologous muscular groups of the opposite limb (according to the law of functional antagonism of

symmetrical centres of the nervous axis). After an attack of fever without known cause, there was a condition of incomplete right hemiplegia, glossalgia, labio-glosso-pharyngeal paralysis, also an attack of hystero-epilepsy, neuralgia of the shoulder, with an eruption of ecthyma, furuncles, and ganglionic engorgement. Hypnotism could not be induced until the third attempt. From that moment the patient rapidly improved. In a fortnight afterwards there having been given two or three daily séances during this period, she was completely cured.

4. In a case of alopecia, where it was desired to dissect off a piece of skin for microscopic examination, the operation was done without the knowledge of the patient or causing any pain during the hypnotic condition.

5. A young man suffering with pain in the knee accompanying coxalgia felt relieved; after the hypnotic sleep the pain had greatly diminished.—*Revue de Médecine*.—*Med. Times*.

#### Cephalic Auscultation in Mental Diseases.

Dr. ADRIANI (*Journal de Méd. et de Chir. Pratiques*) has been conducting a series of investigations upon the transmissibility of the voice to the occiput, with a view to determine its value as a sign of mental disease. The patient should speak in a low tone while the ear of the auscultator is applied to the occiput. He found that in a number of cases of mental disease the voice-sounds were exaggerated or weakened, amphoric, indistinct, or absent. In healthy individuals they were seldom exaggerated or weakened, and never amphoric or indistinct. He thinks that the sound of the voice is transmitted by the cranial bones and not by the brain substance. The latter, however, influences the sound, and it is probably to the difference in its

density that the various modifications of the voice-sounds are due. According to Crichton Browne the density of the brain varies in the different forms of mental disease, and hence Adriani sees ground to hope that cephalic auscultation may become of value in the diagnosis of these diseases.—*Ibid*.

#### The Causation of Pain in the Left Side.

At a recent meeting of the Academy of Medicine, in Ireland, Dr. BEATTY read a paper on this subject, drawing special attention to a form not sufficiently recognized, which was due to fecal accumulation, and removed by getting rid of the accumulation. The pain was felt over the lower few ribs on the left side, was associated with extreme tenderness on pressure upward of the tenth or eleventh rib, scarcely any pain being felt on pressure of these ribs downward, and was relieved when the side was pressed inward with the flat of the hand. He explained its occurrence by the drag of a loaded colon on the pleuro-colic ligament, this constant drag setting up a state of extreme irritability in the nerves of that ligament, so that a painful impression was carried upward along the left lesser splanchnic nerve to the spinal cord, and was transferred, by the law of irradiation of sensations, to the tenth and eleventh intercostal nerves. In the discussion which followed, Dr. Smith said the pleuro-colic fold had not received the attention it deserved. It certainly was of considerable importance in the investigation of abdominal disease. Dr. Beatty's arguments were valid as explaining certain kinds of left-side pain, but did not explain all kinds. Dr. Beatty replied that he did not wish it to be understood that he considered left-side pain was caused in every instance by fecal accumulation, but only

in cases presenting the symptoms he had mentioned.—*British Medical Journal*.

#### Acute Chorea.

A case of this distressing malady is reported in the London *Lancet* as under the care of Dr. GOODHART, at the Evelina Hospital, who treated it successfully by massage without any medication. The choreic movements were of the most violent character, requiring the use of pillows around the sides of the cot to prevent the patient from injuring herself. Her friends were forbidden to see her and she was placed under a special nurse. Massage was employed night and morning for twenty minutes at a time. For the first twenty-four hours there seemed to be no effect produced, and she did not sleep, but in a short time she began to improve and in thirty-four days all choreic movement had disappeared.—*Weekly Med. Review*.

### DIGESTIVE TRACT.

#### Dysentery.

Dysentery is treated by Mr. F. RAWLE after the following plan (*British Medical Journal*): First, having placed the patient between warm blankets, a pint and a half of warm water, at a temperature of 90° Fahr. is injected. This is seldom retained longer than a few minutes, but is pronounced very grateful to the patient. When the water has soothed the mucous membrane of the colon and rectum, and brought away any *effete* matter, two ounces, by measure, of the following enema is administered with a gum-elastic bottle: R Quinine sulphate, ten grains; compound tincture of camphor, four drachms; decoctum amyli, to two ounces. Mix, and when about milk-warm inject, which is gen-

erally retained; but if ejected, it may be repeated after an hour or two. This has been found of great service, and very grateful to the patient, the effect is like magic. If griping pains be felt over the region of the epigastrium, half-drachm doses of chlorodyne, in some aromatic water, mint, caraway or aniseed should be given. The diet, of course, should be of the most soothing kind—jellies, isinglass, linseed, toast and barley-water *ad libitum*. Ipecacuhana appears of little service, and Mr. Rawle has discarded it from his treatment. Warm turpentine stupes on warm flannels, over the hypogastrium, prove very beneficial.—*Weekly Med. Review*.

#### Rectal Constipation.

Dr. BENJ. LEE, of Philadelphia, makes two suggestions (*Med. Bulletin*) for the mechanical relief of this form of constipation. The first consists in applying pressure with the ends of the fingers, protected if desirable by a soft cloth, against the most prominent point of the probulgent mass through the rectal wall, outside of the external sphincter, to convert the concavity of the pouch into an inclined plane, over which a comparatively slight expulsive effort will cause the mass to glide, especially if the inner walls of the annus have been anointed with some bland ointment. The point at which pressure usually proves most effective is just to the left of the sphincter posteriorly; but the finger passed rapidly around will readily place itself where it will do the most good. Patients should be taught to use this simple manipulation when they become conscious of the presence of an accumulation of the the bowel which they cannot extrude.

The second suggestion relates to the shape of the opening in the water closet

seat. The hole of an ordinary seat is circular or oval in shape, and so wide as to admit a considerable portion of the fundament. As the body settles down the fleshy masses of the buttocks are forced together, thus crowding the anus and effectually preventing the opening of the sphincters. The softer and fatter the gluteal regions the greater will be the impediment thus produced, and hence the female will be the more seriously affected. The remedy is to change the shape of the opening, by making its width not to exceed about one-third of the one in ordinary use. The upper edge should be slightly rounded off—not beveled. Seated firmly upon such a support, the *nates* pushed apart rather than forced together, so that an impulse to evacuate will be noticeably excited, and the evacuation will be comparatively easy, requiring but little action of the diaphragm and abdominal muscles. —*Peoria Medical Monthly*.

#### DISEASES OF THE CIRCULATORY ORGANS.

##### Bromide of Potassium in Heart Disease.

The action of bromide of potassium, especially in diseases of the heart, has been the subject of an experimental study by Dr. R. MASSALONGO (*Gay. Med. Ital. prov. Venete*). The doctor arrives at the following conclusions: 1. The action of bromide of potassium on the nervous system, on reflex excitability, is due in greater part to the bromine. 2. The effects on the circulation, respiration and temperature are partly due to the potassium. 3. The effects of bromide of potassium does not quite correspond to the sum of the action of both components. 4. Bromide of potassium has properties and effects peculiar to itself. 5. The action on the circulation and respiration are more

prompt, constant and durable, obtained by small doses of bromide of potassium, than by the use of other salts of potassium.

The action of bromide of potassium is first on the vaso-motor nerves, and induces in the first place constriction of the capillaries, and from this action the effect on the nervous system and heart, the action of which it moderates and equalizes, is made clear. It decreases the waste of innervation, prevents erethism and excitability of the cerebro-spinal axis, and in this way induces sleep in congested states of the brain. In irritability of the heart, where every peripheral irritation excites the trouble, it acts by reducing this peripheral sensibility, and in this way has an advantage over digitalis. It is a tonic for the heart. The dose to begin with for 2-3 days is 30 grs., then 45 grs. for at least 10 days, then a pause of 3 days should be made. If no amelioration is effected, the author then increases the amount to 3 i. or 3 iss. pro die. To give more than 3 ij. is unnecessary. Besides its effect in organic diseases of the heart, it also has a favorable effect on angina pectoris. —*Weekly Med. Review*.

##### Functional Derangement of the Heart.

Dr. ZINSSER, in the *New York Medical Journal*, refers to the case of a gentleman, forty-four years of age, in good health, who was suddenly attacked with distressing palpitation of the heart, without apparent cause, the pulse rising to 160 a minute. He was a moderate smoker and drinker. His urine was free from albumen at the time. Similar cases have been reported where mental excitement or worms have been the cause. Dr. Langemann considers that this condition might be induced by the introduction of strong alcoholic beverages into an empty stomach. Such a practice is occasional-

ly indulged in by army recruits in Southern Germany to deceive the examining physician.—*Med. & Surg. Reporter*.

## DISEASES OF THE URINARY ORGANS.

### Inosuria.

Dr. COCHOT concludes a thesis on this subject as follows: 1. Inosite (muscle sugar) is *never* met with in normal urine. 2. Urine containing inosite may also contain albumen or ordinary glucose. In some cases, however, the glucose disappears entirely, and is replaced for a time by inosite, or *vice versa*. 3. Thus inosuria is not a separate disease, but is a symptom which may be met with in Bright's disease or diabetes. 4. Whenever we find inosite in the urine we have to do with diabetes or albuminuria. The patient is exposed to the same dangers, and the effects of injuries are equally grave. 5. Since inosuria may supervene upon glycosuria it adds another difficulty to the diagnosis of the latter. For inosite does not turn the plane of polarization, neither does it give the characteristic chemical reactions of glucose. 6. Inosuria is to be suspected when the urine, boiled with Fehling's solution, throws down a flocculent precipitate of a greenish color. But certainty is only obtained by a thorough qualitative analysis. 7. It is of great importance to remember that a patient with inosuria is really the subject of Bright's disease or diabetes, in view of the gravity of operations or of wounds in general in such patients.—*Journal de Médecine*.

### Anatomical Changes in Bright's Disease.

From a series of articles in the *Archives Générales de Médecine*, Dr. BRAULT feels justified in formulating the follow-

ing propositions: 1. The group of symptoms understood by the name of Bright's disease corresponds with a variety of renal changes, acute, subacute and chronic, which may be either inflammatory or degenerative. 2. These various renal changes may be due to several causes, or one cause may give rise to different forms of the disease. 3. The first cause of the lesions is probably a chemical alteration in the blood, the nature of which is to be determined in each case. 4. To find expression in clinical signs, the anatomical lesions must be situated in the glomeruli and the lining of the convoluted tubules. 5. The only clinical expression of the renal lesions is albuminuria. This point, however, is still questioned by some writers. 6. The other lesions of the kidney (increase or diminution or contraction of the connective tissue, disseminated fatty degeneration, etc.) which determine the physiognomy or gross appearance of the gland, find no clinical expression. 7. The symptoms, other than albuminuria, of the different forms of nephritis depend upon the retention of excrementitious matters in the blood. 8. This retention is due to an anatomical change, producing a disturbance of function in the secreting portion of the kidney. The anatomical changes upon which this functional trouble depends are numerous, such as acute or chronic fatty degeneration, transformation of columnar into flat epithelium, and finally atrophy and progressive disappearance of this epithelium. The latter is seen in interstitial nephritis of vascular origin.—*Med. Record*.

### Arsenic in Diabetes.

Dr. LONGEVILLE (*Jour. de Thérapeutique*) states that in his experiments he found that arsenic was a great obstacle to the formation of sugar, as shown by

administering it to dogs prior to puncturing the fourth vertricle. Clinical results, as far as observed in two diabetic patients upon whom the experiment was tried, corroborated this conclusion; for a few days' dosing with Fowler's solution, progressively increased from ten to thirty drops per diem, diminished the quantity of sugar by more than one-half. The quantity of the urine passed while under the influence of the arsenic was diminished in like proportion.—*Med. and Surg. Reporter.*

#### Rule for Examination of Urine.

1. Sediment in the urine has no significance unless deposited within twenty-four hours.
2. Albumen in the urine does not indicate kidney disease unless accompanied by tube-casts. The most fatal form of Bright's disease—contracted kidney—has little or no albumen.
3. Every white crystal in urine, regardless of shape, is a phosphite, except the oxalate of lime, which has its own peculiar form, urine alkaline.
4. Every yellow crystal is uric acid if the urine is acid, or a urate if the urine is alkaline.
5. Mucous casts, pus and epithelium signify disease of the bladder (cystitis) or of other parts of the urinary tract, as determined by the variety of epithelium.
6. The urine from females can often be differentiated from the urine of the male, by finding in it the tessellated epithelium of the vagina.
7. Hyaline casts (narrow), blood and epithelial casts signify acute catarrhal nephritis. Much albumen.
8. Broad hyaline casts and epithelial dark granular and oil casts signify chronic catarrhal nephritis. At first, much albumen; later, less.
9. Hyaline and pale granular casts

and little or no albumen signify interstitial nephritis.

10. Broader casts are worse than narrow casts, as far as diagnosis is concerned, for the former signify a chronic disease.

11. The urine should be fresh for microscopical examination, as the micrococci will change hyaline casts into granular casts or devour them entirely in a short time.

12. Uric acid in the urine may in Trommer's test for sugar form a protoxide of copper, thus often deceiving the examiner in the belief that he has discovered sugar. Thus when urine shows only a trace of sugar other methods of examinations besides the Trommer's must be used—preferably the lead test.

13. The microscope gives us better ideas of the exact condition of affairs in the examination of urine than the various chemical tests. Therefore the time has come when every true physician should know how to handle a microscope.—Dr. FORMAD, *Louisville Med. News.*

#### New Theory of Uræmia.

FELTZ and RITTER, of Nancy, having found that simultaneous ligation of both ureters caused a sensible increase, in the blood and in the serum, of the potassium salts, in spite of the supplementary gastro-intestinal excretions, conclude that the alkaline salts follow the same laws as the urea and extractive matters, which increase in the blood under these circumstances. The graver accidents of uræmia, however, do not coincide with those caused by the accumulation and retention in the blood of urea or extractive matters, but, on the contrary, correspond with the phenomena produced by the intravenous injection of fresh normal urine, or of equiva-

lent solutions of potassium salts in distilled water. The authors therefore consider themselves warranted in admitting that the true agents of uræmic intoxication are almost always the potassium salts which have accumulated to excess in the blood.—*Revue de Thérap. Méd.-Chir.*, No. 3.

### DISEASES OF RESPIRATORY ORGANS.

#### The Treatment of Lobar Pneumonia.

In a clinical lecture on pneumonia recently published in the *Lancet*, Dr. FRANCIS DELAFIELD speaks as follows regarding treatment: The treatment of lobar pneumonia calls for the exercise of much knowledge and judgment on the part of the physician. It is necessary to be practically acquainted with the course of the disease and to appreciate fully the exact condition of each patient. There is no routine treatment for pneumonia; each case must be managed on its own merits. If we see a patient during the first twelve hours of a pneumonia, the question presents itself as to whether we shall try to abort the disease. This may be done in two ways: by general bloodletting or by large doses of calomel. The latter plan is the one more frequently employed in New York. From twelve to twenty grains of calomel are placed on the patient's tongue, and this dose may be repeated in six hours. In favorable cases either the bloodletting or the calomel may cause defervescence to take place within a few hours. But both these plans fail in more cases than they succeed. Ordinarily no such attempt is made to abort the disease. Our first care is to put the patient into a condition of absolute rest. He is to be kept in bed, fed on fluid food, and given opium in small doses. Everything which can annoy or

irritate the patient is to be strictly avoided. If the temperature runs between 100° and 104° it requires no treatment. If it rises higher than this we may sponge the skin with alcohol and water, give diaphoretics, and aconite or veratrum viride in small doses. Large doses of quinine, cold baths and cold affusions not only make no permanent reduction in the temperature, but they are positively dangerous. The pulse should regularly be between 100 and 120. If it is above 120 and feeble, we should endeavor to render the heart's action slower and stronger. The most efficient agent for this purpose is alcohol. Either wine, whiskey or brandy can be prescribed. The amount of alcohol used is to be regulated by its effect on the pulse. It is often well to combine with it either opium or the liquid extract of convallaria. This seems to be the only indication for the use of alcohol in lobar pneumonia. Unless it is required as a cardiac stimulant, the patient is better without it. If the breathing is not only rapid but oppressed at the onset of the disease, the patient may often be relieved by the use of wet cups, dry cups, warm fomentations, or mustard plasters over the whole of the chest. If such oppression continues through the disease, it may be mitigated by the use of calomel and opium in small doses, by aconite and veratrum viride and by diaphoretics. For the pain in the side, the restlessness and the sleeplessness the most efficient remedy is opium, selecting the preparation and the dose to suit each patient.

From what has been said you will infer that many cases of pneumonia require no treatment but rest and opium; and it is true. If the disease is running a mild and regular course, you are not likely to improve matters by interference. The only indications for treat-

ment are to relieve an abnormal development of any of the symptoms which may threaten to disturb the patient.—*Med. Record.*

#### A Palatable Cough Mixture.

The most elegant and palatable cough mixture ever prescribed by Dr. J. MILNER FOTHERGILL, is, he says, the following:  $\mathcal{R}$  Syr. scillæ, 3 j.; acid. hydrobromic. dil., 3 ss.; spirits chloroform, 3 ss.; aquæ, 5 j.

#### Morphia and Apomorphia in Coughs.

ROSSBACH (*London Medical Record*) concludes from a series of experiments, that apomorphia, emetin (ipécacuanha), and pilocarpine increase the secretion of the bronchial mucous membrane, and that they are *par excellence* the expectorants, pilocarpine, the strongest, being, however, objectionable, because of its depressing action on the heart. By a proper combination of morphia and apomorphia, we secure the most efficacious cough mixture. Rossbach indicates the following as a guide to such combination:

1. Hydrochlorate of apomorphia may be used as an expectorant; the best prescription is:  $\mathcal{R}$  Hydrochlorate of apomorphia, 3 to 5 centigrammes (about 0.45 to 0.75 gr.); dilute hydrochloric acid, 5 cubic centimetres; distilled water, 150 centimetres. Keep in a black glass bottle. The dose is one tablespoonful every two hours.

2. The combination of apomorphia and morphia lessens the frequency of cough and increases the fluidity of the sputa.  $\mathcal{R}$  Hydrochlorate of morphia, hydrochlorate of apomorphia, of each 3 centigrammes; dilute hydrochloric acid, half a gramme; distilled water, 150 grammes. One tablespoonful is given every two or four hours.

3. Morphia and atropin must be made up separately, as follows: Hydrochlorate of morphia, 2 to 5 centigrammes; distilled water, 120 grammes; red syrup, 30 grammes. The dose is one tablespoonful every two to four hours.  $\mathcal{R}$  Sulphate of atropia, half a milligramme (about 1.150 grain); liquorice powder and juice, enough to make twenty pills. One, two, or three pills are to be taken every night. These pills of atropin are best given in the evening from six to ten o'clock, at intervals of two hours, simultaneously with one or two spoonful of the morphia solution; only the morphia to be given during the day should the cough indicate it. This joint action is recommended in catarrh, emphysema, and phthisis with abundant sputa (when, in the last, this does not come from cavities).—*Med. Age.*

#### Treatment of Coryza with Atropia.

GENTILHOMME gives in acute catarrh of the nasal mucous membrane atropia sulphate in doses of  $\frac{1}{2}$  mgrm. His experience with atropia in this class of cases has been excellent, some cases resembling hay asthma having yielded under its influence that had existed for thirty years.—Gentilhomme, *Union Med. et Scientifique du Nord Est.*

#### Salicylic Acid in Night-Sweats.

The following powder is recommended by Dr. KÖNHORN in the night-sweats of phthisis: Acid salicyl. gr. 45; starch, 3 ijss; chalk, 5 ijss. The entire body of the patient is dusted with this powder at bedtime. The author claims to have obtained great success by this treatment. The same powder is employed in the Austrian army in sweating of the feet.—*Memorabilien.*—*Ther. Gazette.*

# CONSTITUTIONAL DISEASES.

## Some New Discoveries in Regard to Erysipelas.

In a paper read before the Cincinnati Medical Society (*Lancet and Clinic*), Dr. JOSEPH EICHBERG gives a résumé of a treatise on the etiology of erysipelas, by Fehleisen, of Berlin, which treatise he regards as another step in the gradual perfection of our knowledge of the disease. He refers to the various theories of the causation which have obtained, beginning with Galen, who referred the cause to disturbances of the biliary secretion, and continuing down the line to Hüter, who advanced the theory that the erysipelatous virus belonged to the class of micro-organisms. Subsequent investigations have confirmed the theory by demonstrating the presence of micrococci and bacteria. The author differs from Hüter, who considers the virus to be small micrococci in active movement, while he lays special emphasis on the fact of their immobility.

Fehleisen's experiments succeeded in isolating the erysipelas micrococci and in propagating them by culture, producing in this manner in the course of two months fourteen generations. In the manner of their growth they presented peculiarities which at once enabled him to distinguish them from the micrococci of pyæmia and other affections whose germs are morphologically identical with those of erysipelas. The inoculation of rabbits with these artificial culture fluids produced a disease absolutely identical with erysipelas. Patients in the hospital were also inoculated with identical results. In selecting patients for these experiments a double purpose was sought to be accomplished. Remembering the frequent mention in the literature of the subject, of the favorable

influence exerted by a concurrent attack of erysipelas in cases of neuralgia, typhoid fever, acute rheumatism, chronic diseases of joint and various forms of syphilis, lupus and many neoplasms, five of the patients selected for the experiments were affected with morbid growths and two with lupus. In six of the seven cases erysipelas was promptly developed; the seventh case had had numerous previous attacks of erysipelas, the last occurring but three or four months previously, and was supposed to have thus established a tolerance for the virus. Without considering each of these cases in detail, it may be stated that the development of erysipelas in no case did harm, while in three the therapeutic effect was quite satisfactory. Such inoculations are, however, permissible only when hope of benefit from operative interference has passed.

Aside from their therapeutic effect, these experiments are worthy of consideration in deciding the question of the origin of erysipelas. All cases were types of pure erysipelas, as determined by Bergmann, who examined them all in common with many of his colleagues of the Würzburg clinic. In regard to the researches of Lukomsky, Billroth, Ehrlich and Tillmans, who found the micrococci in the lymphatics of the skin and subcutaneous fat, and in the blood-vessels, liver, kidney and substance of the heart, it may be safely presumed that in these cases there was a complication with pyæmia or lymphangitis or phlegmon; in the uncomplicated affection the micrococcus is found only in the lymphatics, which is characteristic of the affection. The spread of the disease does not occur, as in lymphangitis, along the course of the lymph stream, but the dissemination takes place in all directions, frequently against the direction of the lymph current.

With reference to the spread of the disease in any community, there can be no doubt that it is contagious, *i. e.*, transmissible from man to man by direct contact, through the use of instruments, etc., but this is the only or even the usual method of its dissemination. On the contrary, no reasonable doubt can be entertained that the micrococci multiply and generate outside of the human or animal body. Moreover, it is not an easy matter to produce an artificial erysipelas without resorting to the method of cultivation outside of the human body. Many experiments of direct inoculation from man to man have given negative results, which proves that the danger of contagion from a person suffering with erysipelas is not very great. The bacteria, which have entered the body, disappear almost as quickly as they multiply, without ever reaching the surface, and thus having an opportunity to act as the means of secondary infections. The micrococci of erysipelas would then very speedily disappear altogether, were there not some soil in which they might develop other than the human body. As pointing to such a conclusion, there may be cited the fact that in artificial cultures they multiply when cultivated upon potatoes, as well as upon coagulated blood serum or gelatin.

Another interesting feature of the experiments bears upon the question of immunity from second attacks. After a primary inoculation seven persons were vaccinated; six were affected with erysipelas; the seventh patient had frequently been affected and had passed through his last attack a few months prior to the experiment. Of the six other successful vaccinations, two were repeated several times. The third case, successfully, on the 7th of October; subsequently on the 1st and 9th of November, unsuccessfully. In case

No. 5 patient had erysipelas in December, 1881; on the 7th of October, 1882, she was successfully vaccinated with the culture virus; on the 9th of November, thirty-three days after this, the vaccination was unsuccessful. We may conclude from this that one attack of erysipelas confers an immunity of short duration from later attacks.

The author concludes his paper by reporting some experiments made with a view of testing the effect of two antiseptic agents upon the disease germs. The two agents were those used for the dressing of wounds in Bergmann's clinic, a one per cent. solution of corrosive sublimate and a three per cent. solution of carbolic acid. After exposing the germs on a platinum wire to the action of the carbolic acid for twenty seconds no apparent effect was produced, for the artificial cultures developed as rapidly and extensively as before. An exposure of thirty seconds caused an imperfect and retarded development of the cultures, and an exposure of forty-five seconds destroyed them altogether. The solution of corrosive sublimate destroyed them much more quickly, an exposure of ten to fifteen seconds being sufficient to prevent their development on gelatin. As showing the value of antiseptic dressings, suggested by these experiments, the author cites the statistics of the surgical clinic of Bergmann, where, during a period of four and a half years, erysipelas occurred only in two cases treated with the antiseptic dressing, and, he adds, this very limited number may be ascribed to some slight defect in the dressings; and, when it is remembered that erysipelas is of very frequent occurrence in Würzburg, these figures show decidedly in favor of the antiseptic method. When it is further remembered that many cases of opera-

tions about the face and head, where the antiseptic dressing was not applicable, were, during the same time attacked with erysipelas, any additional proof seems unnecessary. The antiseptic dressing will, however, only prove efficient when its application has been preceded by careful disinfection of the wound and of surrounding parts; for this purpose strong solutions of carbolic acid answer best, as they penetrate somewhat into the tissues around the wound, without, at the same time, coagulating the albumen of these tissues, an objection which militates against the employment of corrosive sublimate.

As far as erysipelas is concerned, the labors of Fehleisen seem to decide conclusively a great deal that has hitherto been only speculation and surmise, and, with reference to completeness, are really more satisfactory than the valuable discovery of Koch which they so briefly follow. How far the future physician is to benefit by this work in the field of therapeutics it were impossible to conjecture. It is the first time that artificial culture fluids have been successfully used for the production of disease in man, and the very success which has crowned these efforts will probably serve as an encouragement to many to follow in the path which the author has so brilliantly indicated. We can only hope for the sake of humanity and of our science that those who may come after shall, like Fehleisen, bring to their work scientific acumen, clear observation, and, above all and over all, a sincere desire to relieve suffering and ameliorate distress.—*Med. Age.*

#### The Treatment of Typhoid Fever With Iodo-Phenol.

HUGO ENGEL, A.M., M.D., (*Med. Times*): The German physicians were the first to recommend, as an abortive

treatment in typhoid fever, one or more large doses of calomel to be given in the earliest stages of this disease. There is no doubt that whenever, under such circumstances, large doses of the mild chloride of mercury (from eight to fifteen grains) are administered, a small part of it becomes changed in the alimentary canal into the bichloride. How are we otherwise to explain the well-known fact that occasionally such a dose of this mild mercurial preparation, even if a purgative is sent after it, is followed by grave salivation? The researches of Klebs, Koch and others have undoubtedly proved that in enteric fever bacilli are present, and mainly at the seat of the morbid lesion, whether they be the real pathogenetic cause of the zymotic malady or not. Carefully performed experiments have also established the bacillicidal properties of the bichloride of mercury; no cultures of germs are possible after the natural or artificial germs have been exposed to the action of a one-half per cent. solution of this drug.

Iodine exerts a similar influence; and that here theory and practice harmonize, is seen from the fact that a case of typhoid fever, when treated with iodine, will run a far milder course, as regards the abdominal symptoms, than if not treated with this remedy. That, in case this theory is correct, carbolic acid should induce a similar effect, can be guessed from its antiseptic properties. With the latter drug Rothe has especially experimented, and the success he achieved with this remedy, and the long-established and well-earned reputation iodine has gained for itself in the treatment of typhoid fever, caused Dr. Klamann of Luckenwalde to unite the two remedies, and under the name of iodo-phenol they are now made use of all over the continent of Europe, and are considered to

form the most effective treatment in enteric fever so far known. As this disease may be said to be endemic in most parts of our country, I thought it best to make the readers of the *Medical Times* acquainted with this treatment, and, to give them as much information as possible regarding the same, I will in this article follow closely Dr. Klamann concerning his method and his experience with it. He mentions as the invariable effect of this remedy the following facts :

The discharges from the bowels always diminish in number and become more consistent, and in some cases, if the remedy is given very early in the disease, the latter will run its course totally without diarrhœa ; constipation even will ensue, and this he says took place also when other cases, not treated with iodo-phenol, showed the type of the disease to be one associated with much diarrhœa.

The color of the passages soon assumes a more normal hue. The tongue loses its dryness and becomes moister. The thirst decidedly decreases. The appetite is re-established ; a longing for food, especially solid food (though it would not be wise to permit its being satisfied), is apparent much earlier in the disease, sometimes at the end of the first week—a most remarkable phenomenon, as there is usually the strongest disgust for food of whatever nature.

In milder cases all febrile symptoms cease within a few days after the administration of the medicine has begun. In grave fatally-ending cases, a favorable influence of the remedy on the general symptoms and the general feeling of the patient cannot be denied, but it evidently does not prevent lung or heart complications, nor does it cause any alteration in them.

Intestinal hemorrhage seems to be totally prevented by the medicine. Klamann noticed it only once among one hundred and ninety-six cases treated with iodo-phenol, and this happened during convalescence in a decrepit woman suffering from a tumor of the liver.

In grave cases which have progressed to a late stage, the remedy does not exert such a beneficial influence as when administered in the beginning of the disease.

Sometimes patients will have a disgust for the medicine, and cannot be induced to take it. In such a case it should be administered in some more palatable form, perhaps in gelatin capsules, which are easily dissolved in the stomach.

Occasionally the drug causes an increase in perspiration, but this is never the case to a great degree.

Being afraid of causing intoxication by larger doses of carbolic acid, Klamann administered the remedy in small and repeated doses only. The formula he employed was as follows :  $\mathcal{R}$  Tinct. iodini, 0.5 ; acid. carbolic, gr. x. ; glycerin. ; alcohol.,  $\text{āā}$ ,  $\text{℥}$  x. M. S. : Of this solution from five to ten drops were given in coffee or tea every hour to two hours.

As tannic acid has proved to be a very valuable remedy in the diarrhœa of typhoid fever, Klamann frequently added to this solution the tinctura rhatanhæ. The latter exerts also a beneficial influence on the taste of the medicine.

Notwithstanding the fact that Klamann is rather sceptical concerning the so-called antiseptic treatment of typhoid fever, he was forced to the conclusion that iodo-phenol possesses a curative effect upon the morbid lesions caused by the poison of enteric fever ; but this salutary influence seems to be limited to

the intestinal affection, with which it comes into direct contact. A diminution in the swelling of the follicles, however, a healing of the ulcerations, and a decrease or cessation in the hyperæmia of the intestinal mucous membrane, will *eo ipso* have an antipyretic effect. Considering the great vitality of microzymes, I cannot believe that iodo-phenol has a really antizymotic, bacillicidal, disinfecting influence on the general system, at least in the doses given; its action is purely a local one, and therefore the greater the earlier in the disease it is administered.

Small and repeated doses are by all means to be preferred to larger ones more rarely given. That even the small doses exert an antipyretic effect Klamann noticed in all mild and also in graver cases which had progressed to some extent before the medicine could be administered. Especially in regard to carbolic acid, Klamann believes it to be well to follow the advice of the cautious physician: "Tantum me noceas, dum vis prodesse memento."

#### Disinfection of the Stools in Enteric Fever.

The importance of the thorough disinfection of the stools in enteric fever is, to those who believe in it at all, so great, and its practical results in the control of the extension of the disease are so manifest and direct, that any additional data as to the best methods of employing disinfection cannot fail to be of interest. On the other hand there are quite as many physicians to whom the subject appears to have no importance whatever. These latter either do not believe in the necessity of the disinfection of enteric fever stools, or else they regard it as of so slight moment that it matters not practically whether it be attended to or not, or finally, while professing to recognize its importance, they

adopt in practice imperfect or incomplete measures to accomplish it. Indeed, it may be regarded as the exception to the rule, rather than the rule, both in private practice and in hospitals, to systematically and thoroughly disinfect every stool, even in well-characterized cases of enteric fever. To both of these classes of physicians it cannot but prove of advantage to read the excellent paper on this subject published by Dr. James C. Wilson in the American Journal of the Medical Sciences for April, 1883.

He shows that although the nature of the germ that gives rise to enteric fever is unknown, many facts in its natural history are established by abundant proof. Of these the following have a direct bearing upon this subject: 1. It is invariably derived from a previous case of enteric fever. 2. It is eliminated with the fecal discharges. 3. It is not capable of producing enteric fever at once in susceptible persons exposed to it, but must undergo changes outside the body before it acquires this power. 4. It retains its activity in favorable situations for a lengthened period, the requirements to this end being decomposing animal matter, especially fecal discharges and moisture. 5. In such situations it is capable of reproducing itself. These are the facts which indicate with singular directness the true measures necessary to prevent the spread of the disease, the efficient prophylaxis.—*Med. Age.*

#### Treatment of Typhoid Fever in Ziemssen's Clinic.

From the *Medical Press and Circular*, February 21, 1883, we learn that at the commencement of the disease, if there be constipation, calomel is usually given in doses varying from 0.5 to 1.5 gm. As soon as the temperature in the axilla passes 39.5° C. (103° F.), baths are em-

ployed, generally every two or three hours at the temperature of the room, about  $15^{\circ}$  R. ( $65^{\circ}$  F.). The patient remains *sitting* in the bath about fifteen minutes, whilst the back, neck and chest are being constantly bathed with the water, as in this manner the heat is extracted more gradually and the inspirations are rendered deeper. In some cases of already existing or threatened cardiac weakness the baths are omitted altogether, but only rarely, however; but the temperature of it is raised to  $22^{\circ}$  to  $25^{\circ}$  R. ( $81^{\circ}$ — $88^{\circ}$  F.), and when the patient is in it is gradually reduced some degrees. Some alcohol is given both before and after each bath. If the baths fail to produce a decided effect on the temperature, antipyretics are administered. Rothe's mixture—which consists of acid carbolic and sp. vini ana, 1 grm.; tr. iodi., gtt. x.; tr. aconiti, grm. j.; aq., grm. 50; syr., 10 grm.; ol. menth., gtt. ij., M., and of which a teaspoonful is given hourly—has been extensively employed, but quinine still holds its ground. It is given, not too frequently, in full doses of 15 to 30 grs. every second day. If diarrhœa be profuse, it is checked by the use of starch enemata, to which have been added 20  $\text{m}$  of tinct. opii. This latter also serves the purpose of calming the patient, and thus rendering the attendance less laborious, and may be repeated several times in the course of twenty-four hours. The nourishment consists mostly of broths, with yolk of egg and milk. Wine is given from the commencement, the quantity and alcoholic strength mounting with the cardiac weakness. Stokes' mixture and freshly pressed beef juice are favorites in the height of the fever, or when collapse is threatened. The diet remains unaltered until the eighth day after the subsidence of the pyrexia, after which easily digest-

ed farinaceous and flesh foods are given; whilst the ordinary sick diet is not returned to until after the lapse of another week.—*Med. & Surg. Reporter.*

#### Erythematous Eruption in Enteric Fever.

Two cases of enteric fever, in which there occurred a scarlatiniform eruption, causes Dr. WHIPHAM to ask in the *Med. Press* whether these are really cases of double poisoning of mixed scarlet and enteric fevers. The absence of desquamation, and the fact that an erythematous eruption is not uncommon in variola, pyæmia, and other forms of pyrexia, led to the conclusion that there are really instances of enteric fever preceded by erythema and not mixed cases of scarlatina and enteric fever.—*Ibid.*

#### Absence of the Characteristic Eruption in Typhoid Fever.

Dr. WHIPHAM, of London, related at a late meeting of the Clinical Society two cases of typhoid fever in which there was found, at autopsy, the characteristic intestinal lesion, but the typhoid eruption was not found; on the other hand, an eruption was present which resembled that of scarlet fever. He does not object to the view that scarlet fever and typhoid fever are frequently concurrent.—*N. Y. Med. Journal.*

#### Coffee in Typhoid Fever.

Recently Dr. GUILLASSE, of the French Navy, has given coffee in the early stages of typhoid fever with marked success. Three teaspoonfuls were given adults every two hours, alternating with one or two teaspoonfuls of claret or Burgundy wine. A beneficial result was immediately apparent.—*Med. and Surg. Reporter.*

**Fatal Tetanus Complicating Typhoid Fever.**

Dr. SIMONEAU relates the following: A man, aged sixty-six, was attacked with typhoid fever of rather severe form and a little irregular in its symptoms. The fever had begun to abate, and the patient was supposed to be entering upon convalescence, when he was suddenly seized with vomiting and pain in the epigastrium. On palpation, a rigidity of the muscles of the right side of the abdomen was noticed. A few days later the muscles of mastication became affected, and the patient developed all the symptoms of tetanus, and died in thirty-six hours. The hygienic surroundings of the patient were of the best, and no cause for the tetanus could be discovered. Dr. Simoneau could find no similar case reported of tetanus complicating typhoid fever.—*Ibid.*

**The Proximate Cause of Fever.**

Prof. N. ZUNTZ, from a series of experiments undertaken to discover the source of the increased oxidation and tissue-combustion which occur in the febrile process, concludes that it is to be regarded as residing in the nervous system rather than due to a ferment in the blood. In curarized dogs, it was found that the injection of a pyrogenic agent which caused fever-phenomena in other animals was not in this case followed by increased absorption of oxygen, and the amount of carbonic acid excreted remained constant. The author, therefore, believes that the innervation of the muscles is responsible for the febrile increase of the processes of oxidation in the animal.—*Centralblatt für d. Med. Wissenschaft.*—*Med. Times.*

**Diphtheria.**

A writer in the London *Lancet* is so impressed with the good result of his

treatment in diphtheria that he feels called to publish it (*Philadelphia Medical Times*). He believes the disease to be primarily local, and further, that it always begins in the fauces, never first in the larynx; consequently it is always accessible early. The exudation he finds is checked, and the false membrane to rapidly disappear with early local application of boracic acid. The solution used is as follows: Boracic acid, two drachms; glycerine and water, each half an ounce. This is to be applied freely every hour at first. He advises its continuance for some days after the throat is clear. It appears innocuous, an ounce having been applied frequently within twenty-four hours in young children. In regard to the innocuousness of boracic acid, it should be said that a Russian physician reports two cases in which it proved fatal. In one a five per cent. solution was injected within the pleural cavity after an effusion had been aspirated in a case of pleurisy of three weeks' standing, washing it out and part being allowed to remain. The patient soon began to vomit, did so constantly next day, pulse became small and frequent, hiccough came on, and the patient became feeble. An erythema appeared on the face, with swelling extended, and became vesicular: Other symptoms became more marked, and he died on the fourth day. In the other case a large lumbar abscess was opened and washed out with the same solution; he died on the third day, the same symptoms being observed. No autopsy in either case. It is questionable whether these results were attributable to boracic acid.—*Weekly Med. Review.*

**Transmission of Diphtheria from Children to Fowls.**

Dr. L. ROTH, of Kissengen, reports a violent outbreak of diphtheria among a

barnyard of fowls, which he attributes to infection from children, some of the poison being mixed with the sweepings of the room and thrown into the yard. The *Medical Press*, March 21, 1883, commenting on this, says: "Such an observation as this is very interesting, and seems to bear out some of the statements of Herr M. Wolff, in a paper 'On a Widespread Brute Mycosis.' In it he drew attention to the infectious diseases of domestic animals, which clinically and anatomically run a course exactly similar to those of human beings. He mentioned the fact that anthrax was met with in fowls, geese and ducks, and caused the same phenomena as when its habitat was the mammalia. He also mentioned another devastating mycosis prevalent amongst domestic birds, that bore a complete analogy to diphtheria (*vide* Dr. Roth's observation). Yellow and white-yellow membranes were developed upon the most diverse mucous membranes, having all the characteristics of human diphtheria, so that it could not be removed without causing bleeding. A third disease that had its analogue in man was ulcerative endocarditis, that runs its course with the same valvular changes and multiple emboli in the various organs as in man.—*Med. and Surg. Reporter*.

#### DISEASES OF THE NERVOUS SYSTEM.

##### Trigeminal Neuralgia Relieved by Ligation of the Common Carotid Artery and Neurectomy.

DR. FERDINAND H. GROSS publishes in the *American Journal of the Medical Sciences* a condensed clinical history, extending over nine years, of a case of this disease, with an account of the various remedial measures undertaken for its relief. The result of the operative

treatment may be summarized as follows:

1. The effect of the ligation of the common carotid artery was immediate relief in the domain of the first and second divisions of the trigeminal nerve; the period of immunity from pain in the second division being fully two years, while in the first division the pain has never returned, the relief there being probably permanent, and can only be accredited to the carotid ligation. The effect of this operation upon the third division of the nerve was too transient to count for anything.

It should be added that no impairment of intellect has followed the ligation. After the lapse of nearly two years and a half no disturbance of brain functions has been noticed either by Dr. Gross or the patient, or by any of those who are habitually associated with him.

2. The first neurectomy of the inferior dental nerve, eight months later, resulted in a period of relief from the neuralgia of about one year and three months—to remain within safe limits.

3. The last two operations, viz., the neurectomy of the superior maxillary and the repetition of the operation upon the inferior dental nerve, were performed within two months of each other, September 14th and November 11th, respectively, and may be considered together. The result thus far is entirely satisfactory, the patient being now, three months later, completely relieved of the neuralgia.

##### Diabetic and Nephritic Neuralgias.

DR. BERGER has analyzed a number of cases of neuralgia depending upon diabetes or nephritis. He states that these neuralgias affect usually the sciatic nerve, and more particularly single branches of this nerve, such as the plantar or aural. They show a tendency

to affect both sides symmetrically, are often associated with vaso-motor symptoms, and are exceedingly obstinate to treatment other than that directed against the primary disease. The severity of the neuralgia bears a direct ratio usually to that of the casual disease, although in the cases under consideration it was by means of the former that the organic trouble was discovered. The author is inclined to regard these neuralgias as having a central origin.—*Centralblatt für Klin. Med.*

#### The Pathology of Arsenical Paralysis.

Dr. JASCHKE (*L'Abeille Méd.*) concludes that the paralysis is of peripheral origin, for the following reasons: 1. On account of its localization in the path of a single nerve, the median peroneal. 2. Because of the sensory disturbances, hyperæsthesia and anæsthesia were confined to the same location. 3. The absence of any special symptom of spinal lesion. 4. The absence of atrophy, in spite of the prolonged duration of the disease, excluding the possibility of anterior poliomyelitis, as it is known that atrophy is much less marked in cases of peripheral lesion than when the disease is of spinal origin. 5. Although the paralysis was strongly marked, recovery occurred, rendering the cases analagous to instances of peripheral facial paralysis. 6. The electric reaction corresponded to that seen in peripheral palsies. 7. The existence of pain on pressure in the affected muscles.—*Med. & Surg. Reporter.*

#### Paralysis from Injections of Ether.

In the *Rev. de Therap.*, Dr. ARNOZAN relates four cases from which he concludes: 1. That injection of ether into the muscles causes paralysis. 2. These paralyzes are analogous to peripheric

paralysis. They cause suppression or diminution of faradic excitability. 3. They pass away spontaneously, but very slowly.—*Ibid.*

#### Neuralgia.

Prof. ROBERTS BARTHOLOW recommends equal parts of chloroform, camphor and hydrate of chloral, as an efficient local application to allay the pain of neuralgia. This simple mixture, he recently stated to his class, is very rapid in its anodyne action on the part to which it is applied.—*Med. Brief.*

#### Treatment of Epilepsy by Curara.

The favorable report of KÜNZE (*Neurolog. Centralbl.*) of thirty-five cases of epilepsy, with completely successful results in twenty-five per cent., incited Prof. Edlesfen to investigate this method. The formula used was: Curara, 0.5 gr.; aq. dest., 5.0 gr.; acid. hydr. chlorii, gtt. j.; M., digere per xxiv. horas, dein filtra. Of this, one-third is to be injected hypodermically every five days. No bad symptoms were observed after its use. Out of thirteen cases of true epilepsy three were permanently cured, three others were distinctly improved, six were not benefited, one still under operation promised well.—*Dublin Journal of Medical Science.*

#### Treatment of Epilepsy.

At the St. Anne Asylum, under the care of Dr. BALL, the alkaline bromides are generally used, especially the ammonium salt. The following formula is given: R Ammonii bromidi; sodii bromidi, aa ʒ iiss.; aquæ, ʒ iij. M. A deserts- spoonful to be taken in a cup of a weak infusion of valerian.

Of the above, four doses a day are used at the beginning, gradually increased to eight or ten if necessary. In ob-

stinate cases, the following pill—℞ Ext. belladonnæ; zinci oxidî, aa gr. xv. M. et in pil. No. 40 divid.—may be given morning and evening.

Purgatives may also be needed, either as revulsives or to remove irritating substances, worms, etc., from the alimentary canal. Dr. Ball orders the following: ℞ Aloes socotrin., gr. xv.; resinæ scammonii; resinæ jalapæ; hydrarg. chlorid. mitis, aa gr. viii.; saponis (amygdalin.), q. s. M. Ft. pil. no. 24. Of these, three are to be taken night and morning, once a week.

The bromides of ammonium and sodium are preferred, they being well suited for this purpose by the great facility with which they are tolerated, even in large doses, by their prompt and sustained effect, by the absence of all phenomena of depression, and, finally, by the services which they are able to render in the cases where the bromide of potassium is without effect.—*Revue de Therapeutique*.

#### Epilepsy After Alcoholic Excess.

The occurrence of epilepsy in subjects of chronic or acute alcoholism is not very rare. Dr. W. RAAB (*Wiener Med. Blätter*) lays great weight upon the condition of the brain in such cases, inasmuch as the same result has not been obtainable by animal experimentation. The author considers that where epilepsy appears it indicates a peculiar or diseased state of the brain, either due to inherited defect or to injuries to the head, concussion of the brain, or certain acute diseases developing in the system, which predispose to disturbances in the domain of the central nervous system. A number of interesting illustrative cases are reported.—*Deutsche Medicinische Zeitung*.—*Med. Times*.

#### The Treatment of Epilepsy.

The *Practitioner* contains three articles upon the therapeutics of epilepsy that embody much that is valuable and suggestive. Dr. James Russell considers the remedies used in the treatment of this disease before the introduction of the bromides; but the results reported are far from satisfactory,—whether from iron, zinc, arsenic, strychnia, opium, cannabis Indica, belladonna, spinal ice-bag, blisters, seton, or static electricity, the verdict was almost the same, sometimes temporary improvement, usually ultimate failure.

Dr. Radcliffe continues his medical annotations concerning epilepsy, and discusses especially its treatment. Potassium bromide was introduced by Sir Charles Locock for cases of epilepsy in young women in which erotic excitability seemed to be the prominent element in the etiology. Dr. Radford subsequently extended the use of the remedy to all cases of epilepsy. Of the alkaline bromides, sodium, potassium, and ammonium, he most frequently gives the last named, as being less likely to cause eruptions upon the skin, or to stultify the patient. It also contains a larger proportion of bromine than the others. He usually gives from forty-five to sixty grains in the course of the day. His experience shows that the remedy may be continued in these doses for a long time without injuriously affecting the mind or bodily functions. With regard to large doses, he says that he has not found it necessary to go beyond one drachm a day; and with reference to the selection of appropriate cases, he remarks, "What I have always found is, that the bromide does not act kindly in cases where the memory is bad and the mental power generally enfeebled,—the mischief done, as a rule,

showing itself chiefly in stultification and in disfigurement of the skin by rashes of various sorts, without any very certain change for the better on the attacks. I have indeed found that the attacks were less likely to be kept in check if the bromide was pushed to the extent of causing any stultification or much cutaneous disfigurement, and that it was never advisable to go so far as to produce 'bromidism,' which, to my mind is an evil which is scarcely less ghastly than epilepsy itself. I am quite satisfied that harm rather than good is done by giving large doses of bromide of potassium or bromide of ammonium in ordinary cases of epilepsy where the memory is bad and the mental power generally enfeebled, and that forty-five grains in the course of the day is too large a dose; rather give too small a dose for an adult in such a case. In a word, the conclusion at which I have arrived is that in any case the bromide has been pushed too far if it gives rise to any marked symptoms of 'bromidism,' that in cases of *le haut mal* with much mental enfeeblement this medicine is very likely to be hurtful even when only given in moderate doses, and that in the majority of cases of *le petit mal* the good to be done by it is barely appreciable."

He found great advantage in combining with the bromine salt iodide of potassium, bicarbonate of potassium, and especially chloride of ammonium. Iron is pronounced to be absolutely injurious to epileptics; arsenic, however, is often serviceable. Hypophosphate of sodium he praises particularly for its influence upon nerve-structures, and states that he does "not hesitate to say that the bromide often seems to be almost doubled in remedial value when it is given along with the hypophosphite, or that thirty grains of the bromide, along with

thirty grains of the hypophosphite, given in one or two doses in the course of the twenty-four hours, will go as far in controlling the attacks as forty-five grains of the bromide given by itself. And this is no small gain, for by diminishing the dose of the bromide the risk of stultifying and disfiguring the patient is to that degree diminished." He considers it a mistake to be too ready to associate tonics and restoratives with the bromides in the treatment of epilepsy. The restorative he prefers is a dessert spoonful of brandy, rum, or whiskey, given in the dose of medicine, or else a capsule containing a drop of ænanthic ether after it.

Dr. Radcliffe further insists upon the necessity of proper hygienic treatment, the reduction in nitrogenized food, such as meat and milk, and recommends a greater proportion of fatty or oily matter. Buttermilk or sour milk may be drunk freely, but not fresh milk. As regards sleep, the epileptic should not be allowed too much sleep, as it increases the tendency to convulsions. The mind should not lie idle, and systematic education of both mental and physical powers is absolutely of paramount importance.

Dr. Saundby, in a short article on the "Treatment of Epilepsy," read before the Midland Medical Society, claims that success in the treatment of this affection depends, first of all, upon accuracy in diagnosis; and he draws the distinction very clearly between symptomatic and true epilepsy.

The most powerful and efficient remedies are the bromide salts; he prefers the potassium bromide, ten grains three times a day, which in many cases he has found sufficient. He invariably adds tincture of digitalis (℥x) to counteract any depressing effect. Attention to the diet, the use of occasional laxatives,

and, as a rule, abstinence from alcohol are enjoined. If the remedy should fail to control the convulsions, the dose is to be increased, first by ten grains more of potassium bromide, then by ten of sodium bromide, and finally by ten of ammonium bromide. Oxide of zinc (gr. iiij-v), with extract of cannabis Indica (gr.  $\frac{1}{2}$ ), is also added to each dose of the mixture when the bromides seem to be failing. The use of iron, especially its routine administration, is pronounced very undesirable, and he states that he has seen cases made worse by iron. Cases that are rebellious to the above treatment are sometimes greatly benefited by borax, as recommended by Dr. Gowers, either combined with arsenic or with oxide of zinc.

The attacks of *petit mal* and epileptic vertigo, according to Dr. Saundby, are greatly relieved by the use of caffeine and theine. It is in such cases that the bromides are useless. Nitro-glycerine was also used in two cases, with complete success in stopping the giddiness. Dr. Radcliffe also speaks favorably of coffee and chocolate in the dietary of epileptics, but does not approve of tea.

#### Electrical Treatment of Epigastric Pains in Hysteria.

The *Chicago Med. Jour.*, Feb., 1883, says: These pains, which are mostly accompanied by severe vomiting, have been successfully treated with the galvanic current by Dr. APOSTOLI. The positive pole is applied in the subclavicular region, and the negative pole over the seat of the pain. It is continued for five to fifteen minutes, and it is said to have stopped the vomiting entirely. The gastralgia and epigastric pains have been stopped after ten to fifteen applications.

#### Treatment of Angina Pectoris in the Interval of the Attacks.

GERMAIN SÉE (*N. Y. Med. Jour.*): Besides the ordinary recommendations to persons suffering from heart disease, spirit-drinkers in general, and smokers in particular, to abstain from customary excesses, it remains to do what can be done to prevent the attacks by hygienic and medicinal means. Jurine advises persons who are victims to this painful cardiac affection to live in the country, to keep as free as possible from all care and excitement, to inhabit a ground tenement, to walk and ride a little every day. This advice would be very good if it were practicable.

The medicinal measures which I employ habitually are: 1. Bromide of potassium; 2. Digitalis; 3. Electricity (hardly habitually, but it deserves mention); 4. Arsenic (of which the same may be said); it is sometimes of use as a vaso-motor tonic, but its action is doubtful.

Hydrotherapeutics ought to be absolutely proscribed.

1. Bromide of potassium determines contraction of the blood-vessels, calms the nervous system (particularly the centers of special sense), and induces sleep; it is a regulator of the peripheral movements of the blood. Under its action the patient becomes less impressionable to the physical and psychical influences which might provoke a return of the paroxysm. But this medicine has the grave inconvenience of producing a debility which is more or less permanent, and cannot be continued with impunity beyond a certain time.

2. Digitalis, when the thoracic langor results from cardiac atony or degeneration, presents a real advantage over the bromide; it fortifies and sustains the action of the heart, and is in every way the preferable medicament.

3. Electricity has been applied in divers ways, and in accordance with the different theories which have been put forth as to the nature of the malady. If employed from confidence in the pneumogastric-nerve theory of Eulenburg, and an attempt be made to galvanize this nerve, you run the risk of arrest of the heart's action; the unfortunate case reported by Duchenne is in proof of this.

If you desire to influence the sympathetic alone, in accordance with the theory of Martin and Hachard, there is a practical difficulty in the way, and, moreover, a physiological heresy lurks behind the theory. There is, in fact, no paralysis of the sympathetic to overcome. The disease is in reality attended with excitation of the cardiac sympathetic nerves, and the coronary vessels, the latter being in a state of erethism—there is no paralysis in the case; on the other hand, there is not even excitation of the sympathetic nerves in general, accompanied by a contraction of the blood-vessels in general. The disease (so far as the nerves implicated are concerned) being partial and limited, how are you going to benefit the pathological condition by electrical currents applied to the sympathetic trunk or plexuses? If it were possible to galvanize the cardiac sympathetic nerves, would you not augment rather than diminish vaso-motor contractility? The subject demands further study.

#### DIGESTIVE TRACT.

##### Mercury in Intestinal Obstruction.

From an examination of a large number of cases, BETTELHEIM has come to the conclusion that the use of mercury in bulk (about seven ounces as a dose) is by no means a worthless remedy. On

the contrary, it sometimes saves life in cases of obstruction of the intestine, not yielding to other means, which are due to fecal accumulation, ascarides, twisting or intussusception. No injury, and especially no perforation of the intestine, is caused by it. He therefore recommends that after the use of the ordinary means, such as moderate doses of laxatives, opiates, irrigation of the intestine, changes in the position of the patient, electricity, and massage, mercury in bulk should certainly be had recourse to without fear.—*The Practitioner*.

##### Dyspepsia.

In a very practical address on this subject before the West London Medico-Chirurgical Society (*British Medical Journal*), Dr. HOOD drew especial attention to those cases of gastric lesion in which dyspepsia played an important part as a symptom, and suggested that, in many cases of so-called simple dyspepsia, there was a definite lesion. The carefully-compiled category of symptoms incidental to ulceration of the stomach suggested that the diagnosis was easy, the very opposite of that being clinically the case. In the early part of 1879 he had placed under his charge a gentleman, aged 40, who had spent many years in the colonies. For eight years he had been a sufferer from dyspepsia, the commencement of which he had attributed to irregularities of diet. He first felt pain over the region of the stomach. Soon he suffered from attacks of vomiting and acid water-brash. Failing to obtain relief, he came to England. When first seen, eighteen months after his arrival, his symptoms were much intensified. Blood was found in his vomit. Presently the stomach became intensely irritable, the patient being supported entirely by means of nutrient

enemata. Slowly the grave symptoms subsided, and he regained flesh. In six weeks he went about as usual. Three weeks afterwards, while sitting, on moving suddenly he felt a pain in the stomach, and died within twelve hours. The *post-mortem* examination showed perforation of the stomach at its anterior base. A small healed ulcer, at its base no thicker than tissue-paper, had given way, and the contents of the stomach had been poured into the peritoneal cavity. The stomach, in the immediate vicinity of the pyloric orifice, was honeycombed with the remains of the cicatrices of old ulcers, that presented small depressions corresponding to the position of gastric follicles.

Another patient, whose symptoms bore some resemblance to those of the preceding case, was under his care at the same time. This was a German gentleman, aged 40, who had suffered from painful digestion about fourteen years. In the early days of his illness he had felt pain after taking food. Later he began to suffer from occasional vomiting. When first seen he was rather emaciated. The stomach usually emptied itself at the end of the day. On several occasions a coffee-colored matter had been ejected, and altered blood was sometimes mingled with the vomit. The stomach descended below its natural limit, and a small lump could be felt in the epigastric region, indicating obstructive disease of the pylorus. Under treatment, flesh was gained, the vomiting ceased, and the stomach recovered its natural size, but the lump remained. Subsequently he went to his business abroad, when the symptoms returned, and he died of exhaustion. Ulceration of the stomach was of very frequent occurrence, but the symptoms of ulceration varied very greatly. Although hæmorrhage was an important symptom,

it was not judicious to wait for the presence of blood before inferring the existence of ulceration. In treating assumed ulcer, the patient must be kept in a recumbent posture. Where there was much enlargement of the stomach, Dr. Hood generally used a counter-irritant, and he freely prescribed the various preparations of opium in those cases where there was no doubt that the dyspepsia did not arise from hepatic engorgement; it not only stimulated the bowels, but also made the patient less intolerant of restraint. Where the presence of ulceration was well marked such treatment should be resorted to as would be insisted on if the ulcer occurred on the surface of the body. In the case of a lady, who at the time of first seeing him was afraid to take the simplest food, and in whom there was found in the epigastric region a spot very tender on pressure, he ordered her to bed, recommended rich milk and light broth as diet, and prescribed six drops of laudanum every four hours. Iodine was suggested as a counter-irritant. A simple soap-and-water enema was to be used every other day.

From the first the patient's progress was satisfactory. She left her bed in fourteen days, and recently he received a letter stating that she was quite well.

Dr. Daniel said that three or four years ago he attended a gentleman who had acted as a special artist for a newspaper during the Franco-German war. He was a fine muscular man, but had contracted indigestion. He gave calomel and colocynth, but the symptoms increased, and the patient eventually died of exhaustion.

Dr. Schacht suggested that, in addition to rest, an anema every other day was important. Constipation was an awkward symptom, and the enema, by

relieving the stomach, allowed the opium to do its work.

Dr. Campbell Pope said that he overcame constipation with bismuth in conjunction with belladonna.

Dr. Orton said he knew of a practitioner who had symptoms of ulceration for thirty-five years, and who at last collapsed from vomiting. The *post-mortem* examination revealed ulcers in all stages.

Dr. Hood, in reply, suggested that marked dyspepsia required the most careful examination, for early diagnosis was very difficult. The ulcers were really boils of the stomach, resulting in choked glands. He was strongly of opinion that dyspepsia demanded vigorous treatment.—*Med. & Surg. Reporter.*

#### DISEASES OF THE CIRCULATORY ORGANS.

##### Nitrite of Sodium in Angina Pectoris.

The observations of Dr. MATTHEW HAY upon the effects of nitrite of sodium, and their similarity to those produced by nitrite of amyl and nitro-glycerine, led him to conclude that the peculiar action of these remedies was due to the nitrous acid which they contained. And as nitrite of amyl and nitro-glycerine had been highly extolled in the treatment of angina pectoris, he determined to try the sodium nitrite in the same affection. So far he has had only one well marked case, but the experiments tried in that one, which are reported in *The Practitioner*, were followed by very encouraging results. The patient had been suffering for nearly a year from attacks of pain, which had gradually increased in frequency and severity until they were of a most violent character, and occurred once, generally twice, during the night. The

pain began in the middle of the front of the chest, extended backwards until it was felt between the shoulder-blades, passed down the arms to the tips of the fingers, and was very severe in the right wrist. There was no sense of suffocation, no difficulty in respiration, no sickness and no giddiness. Examination showed slight cardiac hypertrophy, and prolongation of both sounds as heard at the apex. In the aortic area the first sound was followed by a short, soft-blowing murmur, the second by one louder and more prolonged. There was no dropsy and the urine was normal in every respect. Nitrite of amyl was tried at first, which, while it gave relief, did not entirely subdue the pain, and was always accompanied by headache and giddiness. Nitrite of sodium was then given according to the following:  $\mathcal{R}$  Sodii nitritis,  $\mathfrak{z}$  ss.; aquæ ad fl.  $\mathfrak{z}$  xij. Solve. Sig. Dose, one to two teaspoonfuls. It was found that a dose of this mixture would give complete freedom from pain, and if taken promptly when a paroxysm was coming on, it would arrest it in one or two minutes. Comparing the effect of the nitrite of sodium with that of the nitrite of amyl, it was found that the preventive action of the former extended over a longer period than that of the latter. Comparing the rapidity in action of one over the other, it was found that while the nitrite of amyl acted more promptly than the nitrite of sodium, when the latter once took effect, which it did in two or three minutes, the pain was entirely relieved, whereas the former only dulled it and did not shorten its duration. Comparison of the effects of the nitrite of sodium with those of nitro-glycerine showed that although the latter afforded complete relief from the pain, its influence was not as lasting as that of the sodium salt, and it was followed by throbbing

in the head and giddiness, which were not experienced when the sodium was used. In conclusion he says, "it is extremely satisfactory to find from this case \* \* \* \* that in the nitrite of sodium, the simplest of all the nitrous acid compounds, we have a remedy as active in kind and as reliable in effect as nitrite of amyl or nitro-glycerine, and possessing several distinct advantages over either of these in respect, among other things, of producing in therapeutic doses no disagreeable general effects, headache, giddiness, and even partial collapse." The only objection to the use of the remedy is that it is apt to produce eructations of nitrous acid gas, especially when given in large doses, but when the nature of the disease is taken into consideration this is not regarded as a serious one.—*Weekly Med. Review.*

#### Misleading Cardiac Murmurs and Expiratory Auscultation of the Heart.

Dr. HAMILTON OSGOOD describes, in the *Boston Medical and Surgical Journal*, a cardiac murmur occurring independently of anæmia or heart-lesion. The murmur was systolic in point of time, located in the pulmonary area, with but little propagation, and was soft in tone, yet with a suggestiveness of friction. The man, an applicant for life insurance, was the picture of health, not a trace of anæmia, had never had rheumatism nor pleurisy, and never experienced the slightest dyspnoea. The murmur was discovered to be more faint during expiration. Acting upon this suggestion, Dr. Osgood instructed the man to make efforts at expiration and then to hold his breath. When this was done the murmur was found to have disappeared. The author thinks the murmur was due to some slight irregularity of surface in the pericardium, near

the base of the heart. During inspiration the pulmonary pressure increased the friction created in systole, while in expiration pressure was removed. He recommends the practice of auscultation of the heart during forced expiration, when the lung is collapsed, and the heart rests more directly under the ear of the auscultator. True endocardial murmurs become more distinct during expiration, while murmurs like the one described disappear.—*Ibid.*

#### DISEASES OF RESPIRATORY ORGANS.

##### The Origin of Respiratory Murmurs.

CHOMIAKOFF and KOTOVSHTCHIKOFF having repeated the experiments of Aufrecht and Halbertsma, and completed a series of experimental researches of their own (*Dnevnik Kazan. Obst. Vrachei*), sum up their results as follows:

1. Aufrecht's theory is incorrect; that is, the bronchial respiratory murmur does not in the least depend upon the movements of quiescent air-columns within the lung.
2. The bronchial murmur originates exclusively in the larynx; the friction of the air against the walls of the large bronchi does not give rise to these sounds.
3. The vesicular respiratory murmurs are of a compound nature. A large part of them have a laryngeal origin; that is, the bronchial murmur originated in the larynx, while passing through the normal tissues of the lungs, changes its characters, and is heard on the lung-surface as a vesicular murmur. The remaining part of the vesicular sounds originates on the periphery of the lung, but the authors are not as yet able to elucidate its mechanism.

# CONSTITUTIONAL DISEASES.

## Experimental Investigation of the Action of Chloral, Opium and Bromide of Potassium.

In an essay on this subject by Dr. SIDNEY RINGE (*Brit. Med. Jour.*), the author makes the following observations on certain well-known drugs, after discussing the physiological effects of the agents mentioned in the title of their paper: "Clinically, the dangers of bromide of potassium and of chloral have been recognized; and thus in our text-books, we find the statements that the presence of grave adynamic symptoms contra-indicate chloral and bromide of potassium. Opium, on the other hand, in such adynamic states, frequently appears to lend actual support. The results of definite experiment we find to accord with the results of clinical experience; and the value of the former lies in that they confirm, and by their definiteness must tend to enforce the teachings of the latter. The choice of a drug is, however, no simple matter; an advantage here may be outbalanced by a disadvantage there; and practical men may object that they would gladly give opium, but that the disordered stomach, blunted appetite, inactive liver, and torpid intestines, more than outweigh the advantages of opium administration. This clearly is a matter for consideration in the individual case under treatment; and the decision will have to be according as one or other element, asthenia, or derangement of the digestive, etc., powers, is most to be feared. These objections to opium, on the one hand, and chloral and bromide of potassium on the other hand, raise the question as to whether, in very many cases, a drug, at present rather extensively used, especially in America, viz., bromide of sodi-

um, might not with advantage be substituted in their place. The salts of sodium generally contrast very markedly with those of potassium; for the chlorides, bromides and iodides of these two metals, the lowest figure would represent the potassium as ten times as active as the sodium. These precise numbers refer to action on the ventricle of the frog's heart. (See *Medico-Chirurgical Transactions*, vol. lxx., concerning the action of the salts of potash, soda and ammonia, on the frog's heart), but on all hands the evidence is forthcoming that, whilst salts of potassium are very poisonous, those of sodium are very slightly so. One of the marked points of contrast between the two sets of salts to be found in respect of inhibition; potassium salts inhibit the frog's ventricle strongly, sodium salts scarcely at all. Here, however, we are considering drugs as to their cardiac effect and in respect of this, sodium bromide would rank far ahead of bromide of potassium, chloral, or opium, as to innocuousness. The objections holding for opium would not apply here, for sodium salts are generally very little disturbing to the tissues. With these advantages the general verdict of clinical experience is to the efficacy of bromide of sodium as a hypnotic, and, indeed, as a substitute for bromide of potassium; and should this position be maintained, it is clear that bromide of sodium will be in very many cases the sedative above all others to be preferred.—*Med. and Surg. Reporter*.

## Solution of Bromide of Arsenic.

It consists of arsenious acid, 1 part; carbonate of potash, 1 part; bromine, 2 parts; distilled water, to make 93 parts. Boil the carbonate and the acid with most of the water until dissolved; when cold, add the bromine and water

enough to make the prescribed quantity. It is said to improve by age, owing to the combination of the bromine. The dose is one to four drops in water, once or twice daily.

*New Remedies* tells us that it is intended as a substitute for Fowler's solution, and was first proposed by Dr. Clemens, of Frankfurt am Main.

#### Treatment for Gout

Dr. N. S. DAVIS, of Chicago, recommends forty drops of an equal mixture of the acetated tincture of opium and wine of colchicum seeds, to control acute paroxysms of gout. This dose may be repeated in an hour, if necessary. Oftentimes one or two doses will abort what threatens to be a very severe attack. When the paroxysm is under control the same remedies may be continued in smaller doses, three or four times daily, if any gout remains. We have used this remedy, and can add our endorsement to this distinguished recommendation. — *Med. and Surg. Reporter*.

#### Coffee and its Effects.

Dr. P. A. WILHITE read a paper with this title before the last meeting of the South Carolina Medical Association (*Transactions*) in which, after reciting the usual poisonous properties of coffee, he claims that it is more injurious than is generally supposed by the laity or admitted by the profession. He believes that strong coffee, when used to excess, will at least promote, if not cause gout; and its continued use seriously impair the blood, irritate the kidneys, congest the liver, derange the nervous system and paralyze the digestive functions in all their actions, causing acidity, heartburn, tremor, debility, irritability, dejection of spirits, etc. His attention was directed in an especial manner to these poisonous

properties during the late war, when women for whom he had frequently prescribed for a complication of nervous troubles, being unable to procure coffee, became comparatively strong and healthy before the close of the war. He considers that is not so much the quantity taken, as the peculiar susceptibility of some persons to its influence. — *Ibid.*

#### Treatment of Apoplexy.

At a recent meeting of the Soc. de Therapeutique, M. GUYET reported a case which provoked considerable discussion. He was called to attend a patient, whom he found in a state of coma, with marked stertorous breathing, contracture of the lower limbs, and a flaccid condition of the upper. Under these conditions he considered himself justified in bleeding, but hardly a wine-glassful of blood had been taken when the patient sank into syncope and died.

In the discussion M. Dujardin-Beaumez considered first the causation of apoplexy. It is due either to cerebral congestion, or hemorrhage, or to cerebral anæmia.

In cerebral hemorrhage or anæmia, almost impossible to distinguish in practice, and both resulting from vascular lesions, bleeding is contra-indicated. Bleeding to arrest hemorrhage should logically be pushed to dangerous syncope: otherwise it is useless.

In anæmia, bleeding is irrational, and has no influence on the vascular lesions, and the arterial obstructions which are the dominating cause in production of the derangement of cerebral circulation. In the rarer cases of sudden cerebral congestion, bleeding would perhaps be admissible.

M. Constantin Paul believes that bleeding may be of service in apoplexy, not as affecting the cerebral lesion, but as acting on the apoplectic condition,

on the asphyxia and stasis of blood in the veins. He has seen the condition of such patients very markedly improved, particularly where the apoplectic condition followed epileptic convulsions.—*Ibid.*

#### Body Temperature in Different Situations.

DR. HENRY L. TAYLOR (*New York Med. Record*) has found that the difference between the axillary and rectal or vaginal temperature in typhoid fever, while usually about a degree higher in the latter situation, may vary as much as 2° F. sometimes in favor of the axilla, sometimes of the rectum or vagina.—*Med. and Surg. Reporter.*

#### The Salicylates and Hemorrhages in Enteric Fever.

In the *Brit. Med. Jour.*, Dr. JAMES FERGUSON, of Perth, writes: "At the time when salicylic acid and its compounds are receiving so much attention, may not the following facts be regarded as at least worthy of statement? Last year, while resident in the infirmary here, I had an opportunity of testing the efficacy of certain drugs as antipyretics in enteric fever. These agents were used successively, each over a group of cases, and included the salicylate of soda. The latter had not been long in use, when an increased frequency of hemorrhages from the bowel raised the question: Could the salicylate be favoring the production of that complication of the malady? Whether it were or not, the suspicion aroused dictated the withdrawal of the salt from use in cases of typhoid. Shortly afterwards, I noticed that a foreign observer had reported the salicylate of bismuth, and, I think, also salicylic acid (though of the latter I cannot be certain, as I am not able now to find the report in question),

to cause intestinal and nasal hemorrhages. The subject would not have been revived by me at present, but for the recent experience of my successor in the resident's office of the above-mentioned institution, D. H. McLean Wilson, who joins me in placing the facts before the public. Dr. Wilson, in having recourse to the soda-salt in typhoid, found the same striking frequency of hemorrhages to follow closely. His employment of the agent differed from mine, in that he administered small doses of ten to fifteen grains frequently over the twenty-four hours, while I gave half-drachm or drachm doses at longer intervals apart. In the other respect, however, our experiences have been so similar as to warrant the facts being brought under notice, so that the important practical question involved may, if possible, be decided by the evidence of a number of observers.—*Ibid.*

#### Veratrum Viride in Typhoid Fever.

DR. A. W. NELSON strongly endorses the veratrum viride treatment of typhoid, his observations being based upon twenty-eight successive cases in private practice, all recovering. The most obvious beneficial effects were manifested in the reduction of the pulse and temperature, and during this treatment these should be carefully watched. The preparation is the officinal tincture, and the doses are from one to two drops per hour, up to five or more. This is given from the onset of the disease to convalescence. The elimination of the veratrum viride is rather rapid, so that these patients were usually under the influence of from three to twelve drops continuously. It occurred sometimes that the medicine was given only every two hours at night. The entire quantity in twenty-four hours would be from

twenty to forty-eight drops, and this would be continued for from ten to fourteen days. His conclusions were that the use of *veratrum viride* tends to shorten the duration of typhoid fever, so that many cases terminate at twelve days, some at fourteen or fifteen, a smaller number at three weeks, the results being more definite and satisfactory than any other plan of treatment.—*Archives of Medicine.—Med. Times.*

#### Tuberculosis.

Prof. BURDON SANDERSON has been making a long series of investigations, from which he draws the following conclusions (*Practitioner*): 1. The characteristic product of tuberculosis is not an aggregation of shriveled particles of irregular form, but a tissue composed of lymph corpuscles held together by a net-work of hyaline connective substance. 2. There is a close structural analogy between this tissue and that of certain follicular organs belonging to the lymphatic system, *e. g.*, the follicles of Peyer, the ampullæ of the lymphatic glands, etc. 3. All the favorite seats of tubercle are naturally characterized by the presence of this tissue, which, from the analogy stated above, may properly be called adenoid. 4. The natural distribution of adenoid tissue in the body is in intimate relation with the lymphatic system. In the great serous membranes (which v. Recklinghausen's discoveries have taught us to regard as walls of lymphatic reservoirs) it forms sheaths round the blood-vessels, or masses of microscopical dimensions and irregular contour underneath the epithelium. In the solid viscera it is distributed here and there in the course of the lymphatic channels. 5. In the peritoneum tuberculosis primarily consists in the enlargement or overgrowth of these sheaths or

microscopical masses of adenoid tissue, and consequently the tuberculous nodules which are formed have the same intimate structure, and stand in the same anatomical relation to the vessels and epithelium. In the viscera the essential lesions also consist, not in new growth, but in over-growth of pre-existing masses of adenoid tissue. 6. The primary lesion in artificial tuberculosis, whether the cause be simple wound or specific inoculation, consists in the development, at the seat of injury, of granulations or nodules, which have similar structural characters with those of adenoid tissue elsewhere, but cannot as yet be shown to be in relation with the absorbent vessels. 7. The first step in the dissemination of tubercle consists in its being absorbed primarily by the lymphatics (which convey it to the lymphatic glands of which they are tributaries), and secondarily by the veins. Having thus entered the systemic circulation, it is distributed universally by the arteries. The serous membranes seem, however, by preference, to appropriate it, and from them it extends by contiguity to the superficial parts of the organs which they cover. 8. The final stage of the process consists in the tertiary infection of the glands of each diseased organ, which glands consequently undergo enlargement and induration, and eventually become partially caseous. The enlargement is due to the multiplication of cells in all the tissues of the organ, but more particularly in the alveoli—the hardening to a process of fibrous degeneration—while the caseation consists in slow necrosis of the previously hardened and anæmic parts. From the first the gland is incapable of performing its functions, but it is not until induration commences that the absorbents of the organ to which it belongs are completely ob-

structed. 9. In the liver of the guinea-pig, and in some other organs, tuberculous tissue undergoes a fibroid degeneration and caseation, the results of which cannot be distinguished from those observed in the normal adenoid tissue of the lymphatic glands and of the spleen. 10. As regards the question of specific contagium of tubercle, we think it very important to note that this is not yet disproved by the facts of traumatic tuberculosis. It still remains open to inquiry whether or not injuries which are of such a nature that air is completely excluded from contact with the injured part are capable of originating a tuberculous process.—*Weekly Med. Review.*

#### Pathology and Radical Cure of Hay Fever.

Dr. J. O. ROE (*N. Y. Med. Journal*) concludes an interesting article on this subject as follows:

Thus, from the study of hay fever in the light of the most recent investigations as to its cause, and our present knowledge of nasal diseases and their influence on other organs, we may draw the following conclusions:

1. That hay fever is an affection not confined to age, sex, or condition in life.

2. That it is excited by the pollen of flowers or grasses, dust, or other irritating substances floating in the atmosphere, which are brought, by inhalation, in contact with the nasal and bronchial mucous membrane.

3. That the nasal mucous membrane in certain individuals is very susceptible to the irritating effect of these substances, while in others it is not.

4. That this hyperæsthesia is associated with or occasioned by a diseased condition, either latent or active, of the naso-pharyngeal mucous membrane and with an hypertrophied condition of the

vascular tissue covering the turbinated bones and the lower portion of the septum.

5. That the systemic disturbances, such as asthma, etc., are the effect of the local irritation of this diseased tissue in the nasal passages which is reflected to the larynx, bronchi, and lungs, causing in them a fluctuatory hyperæmia, produced through the correlating function of the sympathetic ganglia connecting these different regions.

6. That the treatment during the attack can only be palliative, such as to soothe the inflamed parts and to quiet the systemic disturbance which may be occasioned.

7. That in most cases the only effective relief during the attack consists in going to a seaport or mountainous region, or to any locality where the air is free from the substance which produces the irritation.

8. That curative measures can only be adopted when the individual is free from the attack.

9. That the removal of the diseased tissue in the nasal passages removes the susceptibility of the individual to future attacks of hay fever.

#### Cultivation of the Soil vs. Malaria.

It would seem from the crucial test of experience that cultivation of the soil of malarious localities is not only the most influential, but really the only means of eradicating the poison. A new proof of this fact comes from the Abbey of the Tre Fontane, in the Roman Campagna. At first the monks were obliged to live within the city walls during the unhealthy season, but since the ground has come under cultivation, and, above all, since the eucalyptus globulus has been planted on a large scale in the neighborhood, the Abbey has been inhabited all the year round, and the

fevers from which its inmates suffer are of a mild character, and rarely fatal, while formerly something like a fourth of the community succumbed every year.—*Med. and Surg. Reporter.*

#### Granulated Milk.

The *Med. Record* says that granulated milk is made by subjecting milk to a temperature of  $130^{\circ}$  until the watery part has been evaporated. It is then granulated, and sugar is added, when it looks like corn meal. The evaporated milk is not as solid as condensed milk, and when water is added it cannot be distinguished from natural milk.

#### Displacement of the Heart and Syncope in Pleurisy.

Dr. TCHIRKOFF has undertaken a series of experiments on dogs in order to elucidate two points: first, the causes and mechanism of cardiac displacements; and second, the causes of syncope in patients suffering from exudative pleuritis. He has arrived at the following conclusions: 1. In all cases of pleuritic effusion, the first change in the position of the heart consists in a rotatory movement round the long axis from right to left, the apex invariably turning to the right. 2. This rotation depends upon the increased filling of the right side of the organ, in consequence of narrowing of the blood-current in the pulmonary artery. 3. With increase of the exudation and diminution of negative pressure within the corresponding pleura, the difference in pressure between the affected and healthy pleuræ finds its expression in a displacement of the heart toward the healthy side; the displacement to the right (*i. e.*, in cases of left-sided effusion) always being greater and developing

more rapidly than that to the left. 4. The apex and the base are displaced simultaneously, but the former in a greater degree than the latter. 5. Positive pressure of an exudation acts only on the distended pericardium and mediastinum, but not at all on the heart itself. 6. Therefore, any extensive displacement of the heart, under the influence of sudden or forcible movements of a patient, cannot take place, for the force of pressure is not excited on the heart, but on various other very elastic structures. 7. In cases of very considerable pleuritic effusions, no rotation of the heart (from right to left) is usually observed; the organ may even appear rotated from left to right under the positive pressure produced by the exudation on the right side of the heart. 8. The sudden death of pleuritic patients cannot be caused by displacement of the heart and sudden compression of the inferior vena cava (as Bartels teaches); for neither experimental cardiac displacements nor a few minutes' compression of the vein in dogs could bring about any attack of syncope; besides, as it is already stated above, any extensive displacement of the heart in a pleuritic patient is impossible. 9. As the author's experiments show, a heart which is exhausted from accommodative work in a case of the pleuritic effusion may be easily and irrecoverably stopped by irritation of one of the vagus nerves; from this experimental fact he concludes that pleural inflammation spreading over the mediastinum may exhaust the heart through directly acting on the cardiac nerves, and so may produce an attack of syncope. According to the author, syncope may occur even in cases of scanty effusion, or after the operative removal of the fluid and after cessation of the compensating work of the heart. As one of the causes

leading to exhaustion of the heart, the author points out an excessive quantity of carbonic oxide present in the blood of pleuritic patients. In conclusion, Dr. Tchirkoff recommends, while oper-

ating in empyema, to keep in view that an exhausted heart may be easily stopped in a reflex way, *e. g.*, in consequence of pain caused to the patient.—*London Medical Record.*

### Membranous Croup and Diphtheria.

Dr. J. R. MARSHALL (*Columbus Medical Journal*). My views can be best presented in the form of a comparison between the two diseases :

#### Membranous Croup.

1. Is a sthenic or acute inflammation of the mucous lining of the bronchia.
2. Is ushered in with violent functional and constitutional disturbances, such as cough, fever, hoarseness, with dyspnea.
3. Duration is comparatively short, runs a rapid course—from five hours to two or three days.
4. Is not contagious or epidemic.
5. Is peculiar to children under ten years of age.
6. No fetor of breath.
7. Breathing short, with slight expansion of chest, and livid countenance.
8. There is no ulceration of mouth or throat.
9. Termination in resolution (recovery), or in death by apnea.
10. Treatment: Anti-phlogistic and sedative. Mercury, antimony, opium, and tobacco are serviceable.

#### Diphtheria.

1. Is an asthenic or subacute inflammation of the mucous lining of the fauces, larynx, pharynx and nares.
2. Comes stealthily, less violent, without cough or dyspnea.
3. Duration is comparatively long, runs from five to twenty days.
4. Is epidemic, and by many authors is considered contagious.
5. Is common with all ages and sexes.
6. Always a bad fetor of breath.
7. Breathing longer and deeper, with greater expansion of chest and less lividity.
8. There is often extensive ulceration which may cause septicemia and entire arrest of assimilation and nutrition, and failure of the heart's action as a consequence.
9. Termination in resolution (recovery), or in death by asthenia.
10. Treatment: Tonic and antiseptic. Mercury, antimony, opium and tobacco, either or all, would do great harm and complicate, and lead to fatal results.

#### A Prescription for Acute Rheumatism.

In the *British Medical Journal*, April 7, 1883, Dr. J. MORTIMER GRANVILLE says : In acute rheumatism, as early as

possible in the case, give the mixture described below, in the diluted form in which I have prescribed it. Do nothing else, except to pack the painful joints

in wraps of very loose cotton-wool, covered with light flannel; not oil-silk or any other vapor-proof material.  $\mathcal{R}$  Tincture aconiti, (*P. B.*)  $\mathfrak{M}$ xij.; ammonii sulphidi,  $\mathfrak{M}$ xvj.; aquæ menthæ viridis destillatæ,  $\mathfrak{z}$  vj.

The dose is a fourth part, every fourth, or, in severe cases, every third hour, until the pain is relieved and the "fever" has abated. The mixture should not be prescribed in larger quantity than will suffice for four doses, on account of the tincture of aconite, and, more especially, the tendency of the sulphide of ammonium to decompose and deposit sulphur.

#### **The Micrococcus of Cerebro-Spinal Meningitis.**

In a case of sporadic cerebro spinal meningitis reported by E. LEYDEN (*Centralblatt für Klin. Med.*, x.) an examination of the recent lymph lying under the pia mater of the spinal cord (obtained, without injuring this membrane, by a Pravâz syringe) showed a great number of micrococci, occurring both singly and in chains. These organisms were oval in form, and, although larger, in general appearance they resembled those found in pneumonia and erysipelas. Prepared with methyl-blue and fuchsin they had beautifully characteristic appearances. These organisms were also detected in the pia mater itself.

The presence of similar forms has been previously demonstrated in the exudative meningitis after pneumonia, as well as after injury to the skull. The reporter refers to this similarity, and considers it of interest that three diseases which in their anatomical forms and their course present so many points in common should also be associated with analogous micro-parasitic forms. Pathological anatomy had established the analogy between

meningitis and erysipelas even before the parasitic element was talked of. This agreement appears sufficiently important to be mentioned here, and to recall the fact that erysipelas and pneumonia are not seldom associated with meningitis, whilst cerebro-spinal meningitis, even the epidemic form, is not rarely ushered in by a pneumonia. —*Deutsche Medicinal Zeitung.*

### **DISEASES OF THE NERVOUS SYSTEM.**

#### **Sciatica.**

In a clinical lecture on sciatica, published in the *Medical Times*, Dr. Wm. PEPPER calls attention to the difference between the disease as an idiopathic affection and occurring as a symptom of deep-seated trouble. This distinction is very essential in determining the measures of treatment. Thus an aneurism of the aorta may by pressure cause pain in the course of the circumflex, the genito-crural, the ilio-inguinal or the sciatic nerve, and in leucæmia there may be such enlargement of the abdominal gland as to cause sciatica by pressure. In such cases the treatment must, of course, differ from that demanded in simple sciatica. The cause of the latter may be malaria. Periodicity, though it generally does, does not always denote malaria as the cause. In all neuralgias painful spots are found over the points of exit of the nerve affected. In sciatica the painful spot is where the nerve passes through the sacro-sciatic foramen. In purely malarial sciatica it has seemed to Dr. Pepper that the tenderness is less marked at this spot than when malaria is not the cause, so that excessive tenderness and the point of emergence and excessive pain on motion are evidences of non-malarial origin. Lead-poisoning may be the cause of the affection. The

cause, however, is most frequently congestion of the nerve-sheath, often associated with a gouty or rheumatic diathesis; but even when such diathesis does not exist congestion may be caused by exposure to damp and cold. The latter is the most common cause. In addition, sciatica may be the expression of a neuralgic constitution. In the latter case the individual is usually anæmic and of a morbidly sensitive nature. Treatment must be based on a careful consideration of the cause. To relieve the pain give injections morning and evening into the deep tissues of the thigh of a solution of morphinæ sulph. gr. 1-6 and atrophinæ sulph. gr. 1-80. Such deep injection is more effective than the simple hypodermic injection.

It is an old observation that puncturing the tissues over a painful nerve would relieve the pain. The practice of acupuncture, by plunging solid needles into the tissues, for the relief of neuralgia, dates back thousands of years in the Chinese practice of medicine. In China there is a caste or class of people whose business it is to practice acupuncture. The needles which they use for the treatment of sciatica are very long, made of fine gold, brought to an exquisite point, sometimes worked with a fine spiral and sometimes perfectly smooth. These are rapidly rotated between the thumb and index-finger and inserted to a great depth. It has been supposed that the relief afforded is due to puncture of the nerve-sheath, allowing the escape of some exudation which causes pressure upon the nerve. This, however, is not at all probable, for the anatomical knowledge of those who practice this treatment is very slight, and even if they succeeded in reaching the nerve-sheath the needle would probably be introduced too far and injure the nerve

itself; and, again, the opening would be so small and the tissues are so elastic that very little fluid could escape.

While confidently recommending hypodermic injections of morphia in acute sciatica he earnestly protests against their use in chronic neuralgia. In no other disease will the opium habit be more readily contracted than in chronic neuralgia. The attacks come on so frequently and so violently that the patient soon becomes the victim of this most troublesome habit.

Counter-irritation over the affected nerve should be used. A blister first, but if the case proves obstinate the actual cautery should be resorted to. The blister should be three inches by four inches.

Internally for two or three days, give thirty grains of quinia a day should malaria be suspected, and, even if there is no malarial element, the effect of the quinia upon the vessels of the affected part and its influence upon the general nervous system cannot fail to be of benefit. After a few days the dose of quinia should be diminished and arsenious acid be associated with it. When the injections are stopped give also belladonna and iron. Iodide of potassium, five grains four times a day will be found necessary from the first.

#### Capsicum as an External Application.

J. A. E. STUART recommends the use of capsicum as a rubefacient application in lumbago and strains of the muscles of the back. He uses the following formula:  $\mathcal{R}$  Tr. capsici,  $\mathfrak{z}$  i.; ol. olivæ, ad  $\mathfrak{z}$  vi. M. Sig.: Lini-ment to be rubbed in frequently.—*St. Louis Courier of Medicine*.

**DIGESTIVE TRACT.****Iodine Blisters in Tabes Mesenterica.**

The *Med. Press* says: In tabes mesenterica, Dr. BOUCHUT, of the Children's Hospital, recommends the application of blisters, or the tincture of iodine, upon the abdomen, and if ascites were present, tapping should be employed without hesitation. The *régime* to be followed should be very severe—beef-tea, eggs, raw milk, and claret. If diarrhœa be present, enemas of borax, one drachm each time, should be given, and three or four teaspoonfuls of glycerine in the day, by the mouth. Bismuth, or phosphate of lime, would be very useful. Your correspondent tried this treatment in an apparently hopeless case, and a rapid recovery ensued. The disease was far advanced, and the child was abandoned by its ordinary medical attendant.

**Sulphate of Quinine in Colic.**

Dr. N. R. DERBY writes to the *Medical Record* of December 2d that he discovered, by accident, that a dose of eight or ten grains of sulphate of quinine will speedily put an end to an attack of colic. Since childhood he had himself been a frequent sufferer from this distressing trouble, but since this discovery he has been able to arrest an attack either in himself or others. His observations extend over a period of three years, and have embraced many cases.

**Mettauer's Laxative.**

This preparation is said to be composed of—Socotrine aloes, 2 ounces; bicarbonate of soda, 6 ounces; comp. spt. lavender, 2 ounces; aquæ, 3 pints. Macerate for a fortnight and filter. Dose, one to four teaspoonfuls one hour before dinner.—*Med. Brief.*

**Rectal Alimentation.**

Prof. JAMES TYSON gave the following directions for preparing food for rectal alimentation: Take one-half pound of fresh pancreas, the so-called sweet-bread of the market house; mince it well and pulpify it in a mortar with water at 100° Fahr.; then strain through a cloth, and mix it thoroughly with one and one-half pounds of minced beef (without fat, and the yolk of an egg). Stand this aside for two hours. Use one-half of this for one enema, and use it in one day, as it will not keep longer. It ought to be prepared fresh daily.

**Percussion of the Colon in Diarrhœa.**

Diarrhœa depending upon fecal accumulations in the lower bowel (*diarrhœa paradoxa*) is a well-known condition, the treatment of which by laxatives is of long-recognized utility. The diagnosis, however, between this form of diarrhœa and that other whose location is, more strictly speaking, in the small intestine, has often presented considerable difficulty. In an article upon this subject, in the *Deutsche Medicinische Wochenschrift* of February 14, 1883, Dr. GOEDICKE advocates the systematic practice of abdominal percussion in all cases of diarrhœa. He was led to adopt the practice in this wise: Several years before, when a young army surgeon, his suspicions were often aroused by the number of soldiers coming to him with the complaint of diarrhœa. In order to detect the malingerers, he made use of percussion of the colon, reasoning that in genuine diarrhœa the descending colon should be empty, and therefore give a tympanitic percussion note. He was surprised, therefore, to find that the contrary was usually the case. In most of the men in whom diarrhœa actually existed, as was ascertained from the re-

ports of the infirmaries orderlies, the percussion note of the descending colon was dull.

The investigations now undertaken led him to the following conclusions : 1. In a healthy individual, with normal movements, if we percuss the colon, we shall find that the left iliac fossa usually gives a flatter note than the right. 2. In patients suffering from diarrhœa the greater dulness may be on either side, but is usually, in otherwise healthy persons, on the left. 3. The same condition obtains in children. 4. Whenever there is tenderness on pressure, it is found on the same side as the greater dulness. 5. The term "dulness" is to be understood as relative and not necessarily absolute, for the percussion note on both sides may be actually tympanitic if the colon be distended with gas.

The author asserts that by far the more common form of diarrhœa is that excited by fecal accumulation in the large intestine. It is this variety which is characterized by increased relative dulness in the left iliac fossa, and in which opiates and astringent remedies are contra-indicated. In the other form of diarrhœa the trouble is in the upper bowel, and here the percussion note upon the right side is more dull, or less tympanitic, than that on the left. It is in these cases that the ordinary diarrhœa medicines find their application. Dr. Goedicke concludes by urging the practice of abdominal percussion in every case of diarrhœa, where possible (it is always possible in children, and it is in children that the knowledge of the true nature of the trouble is of the greatest importance). And he states his conviction that the more general this practice becomes, the less frequently will opium be employed in the treatment of diarrhœa.—*N. Y. Med. Journal.*

#### Extract of Calabar Bean.

This medicament has been recommended as an heroic remedy in obstinate constipation. Recent experiments undertaken in the service of Prof. LEYDEN, of Berlin (*Deutsch. Medic. Woch.*), demonstrate that this extract has a very rapid and sure action in atonic states of the intestine, characterized by flatulence, meteorism occurring just after meals, a sensation of weight in the epigastrium, habitual constipation, etc. The medicament was given in this form :  $\mathcal{R}$  Ext. calabar bean, 1 centigram; glycerinæ, 30 grams. M. Et. S. : Ten drops daily. The patients are greatly relieved, but the benefit is rarely durable, and if the remedy is continued for any length of time the toxic accidents are apt to supervene—*Med. and Surg. Reporter.*

#### DISEASES OF RESPIRATORY ORGANS.

##### Pancoast's Cough Mixture.

The following formula (*Medical Bulletin*), said to have originated with the late Prof. PANCOAST, of Philadelphia, has the advantage of containing no opium or morphine, since many persons cannot take either of these remedies without discomfort :  $\mathcal{R}$  Wild cherry bark; senega,  $\mathfrak{aa}$   $\mathfrak{z}$  iv.; ipecacuanha,  $\mathfrak{z}$  ij.; extract of conium, gr. xv.; water, q. s., ft. (by displacement) fl.,  $\mathfrak{z}$  viij. Then add :  $\mathcal{R}$  Gin,  $\mathfrak{z}$  i.; compound tinct. of cardamom,  $\mathfrak{z}$  i. Two teaspoonsfuls in water constitute the usual dose to relieve coughs.

##### Prophylaxis against Phthisis in Hospitals.

From a series of experiments upon tubercle-inoculation, and the effects upon the process by different disinfecting agents, M. VALLIN has found sulphurous acid the most efficacious in pre-

venting contagion. He therefore recommends that, in hospital wards where the air is infected by tuberculous patients, from time to time the rooms shall be vacated and thoroughly fumigated with sulphurous acid.—*La France Médicale*.—*Comptes-Rendus de l'Acad. de Médecine*.—*Md. Med. Jour*.

#### Nervous Cough.

Before a recent meeting of the Boston Society for Medical Improvement (*Boston M. and S. Jour.*), Dr. BOWDITCH reported a case of cough lasting sixteen months, apparently, except for the duration and violence, a case of typical whooping-cough. Laryngoscopic examination showed nothing. At the lowest part of the chest, outside the heart, was crepitation for a space of one or two inches, but no dullness. He supposed the cough to be nervous.

Dr. Knight said that he had seen many cases of what he thought nervous cough, and which were usually benefited by nerve sedatives. One case has yielded to enormous doses of quinine, beginning with two grains, and gradually reaching fifteen or twenty at a dose.—*Med. and Surg. Reporter*.

#### Bronchitis.

For the relief of the laryngeal and bronchial irritation attending all the stages of an ordinary attack of bronchitis, Prof. A. C. POST highly recommends the following:  $\mathcal{R}$  Ol. amygdal dulc,  $\mathfrak{z}$  ss.; mucil. acaciæ,  $\mathfrak{z}$  ijss.; syrup tolu,  $\mathfrak{z}$  i.; chloroform,  $\mathfrak{z}$  i.; morphinæ sulph., gr.j. M. Dose, a teaspoonful once in four hours.—*N. E. Med. Monthly*.

#### A Prognostic Sign in Pneumonia.

Dr. J. B. SULLIVAN, of Stanton, Michigan, contributes the following:

I have had considerable experience in the treatment of pneumonia, and have realized, as every practitioner must, that it is a formidable disease. I think I have detected a symptom which, when discovered, indicates an unfavorable prognosis, and the absence of which justifies a promise of recovery. I have relied on it for twenty years. In a case of typical pneumonia we have five stages, viz., engorgement, red hepatization, gray hepatization, suppuration and resolution. Dr. Stokes describes a stage of arterial injection, before engorgement, but I am content with regarding this as the first stage. Engorgement is congestion of the pulmonary vessels. During red hepatization the lung has a dull reddish-brown tint, and in this stage the sputa will reveal a breaking down of the lung substance if such destruction is taking place. The pleura almost invariably participates in the inflammatory changes when the superficial portion of the parenchyma is affected. When red hepatization has existed for some days (as it usually does) the color becomes paler and whiter. Gray hepatization succeeds the red, and its occurrence may be detected by the color of the sputa. It is at the onset of this stage that we have our sign. If the stage of red hepatization, as indicated in the characteristic reddish sputa, do not continue for at least thirty hours, the patient will die. This has been my experience.—*Med. Age*.

#### The Treatment of Pneumonia.

Prof. BAMSLER, of the University of Friburg, Baden, directs his efforts chiefly towards sustaining the patient's strength until the disease leaves him—so he says in a letter to Dr. W. Thornton Parker (*N. Y. Med. Record*). The pyrexia being a chief cause of exhaustion, the endeavor is to

keep down the body-heat, which he does by cold baths, wet packing and quinia in 15 to 20 gr. doses, in the evening, or grains 60 to 80 of salicylate of soda within an hour in the middle of the night. The patient's diet must receive careful attention. See to it that he is sufficiently nourished, as by broths, beef tea, milk, and a half to a pint of light wine, in twenty-four hours. When there are *pleuritic pains, an ice bag is applied to the chest*. Restlessness, great pain or diarrhœa is to be met by morphia or Dover's powder. If bronchial catarrh is a prominent symptom, ipecacuanha in infusion is administered. He never employs sweet spirits of nitre in pneumonia.

#### Actinomycosis in the Human Subject.

MOSSDORF and BIRCH-HIRSCHFELD report (*Dresden Jahresbericht für Natur und Heilkunde*) a fatal case of actinomycosis which was diagnosticated during life. The case had for six months suffered with symptoms of pleuro-pneumonia, or an encapsuled purulent pleural effusion, with occasional pyæmic chills, rapid emaciation, and colliquative discharges. The right pleural cavity contained masses of actinomycoses, which had invaded also about two-thirds of the right lung. There was also a fistula running beneath the muscular structures and the sternum. The pleural cavity, as well as the fistula, was partly filled with grayish-yellow stinking masses with scattered sulphur-yellow conglomerations of the spores of the fungus, and partly with a tough, jelly-like tissue which contained the former in considerable quantity. No collection of fungus was found in the mouth, but it existed in the bronchial tube of the left side, on the heart, and in the left kidney. In the right lung the tissue was to a great extent gangrenous, but on sec-

tion there were still seen bronchial aggregations of the fungus, mixed with epithelial cells.—*Centralblatt für d. Med. Wissenschaften*.—*Med. Times*.

#### Chronic Nasal Catarrh.

Dr. ADDISON HICKEY thus closes an interesting article on this subject in the *Medical Herald*:

In the treatment of this disease the first thing to be done is to thoroughly cleanse the parts. This is of paramount importance. The means employed to accomplish this should be mild and non-irritating. Anything which produces pain which lasts longer than a few seconds should not be used. I usually use for cleansing purposes the following mixture, which is a modification of "Do-bell's solution": R Sodæ bicarb., sodæ biborate, āā ʒ ss.; glycerine, ʒ ij.; listerine, ʒ j.; aquæ., ʒ v. M. Ft. sol.

This solution, when used slightly warmed, produces a very pleasant sensation, and is excellent for cleansing and disinfecting the nasal cavities.

It should be used in the form of a spray, and Rumbold's, or preferably Sass's spray-producers are the best instruments for accomplishing this purpose. Unless there is a large accumulation of mucus or mucous-purulent matter in the nasal passages (or vault of pharynx) a detergent is unnecessary. In many cases the passages can be thoroughly cleansed by blowing the nose vigorously.

I propose now to very briefly review the method of treatment employed in each of the varieties of nasal catarrh alluded to.

1. *Chronic Coryza* (catarrh). In the treatment of this variety, as well as most of the others, I use, with some modifications, the method originated by Dr. Rumbold. This consists in using in the

form of a spray vaseline and ext. pinus canadensis. Unlike the distinguished author alluded to I have added to my armamentarium many other remedies besides the two mentioned. I use vaseline as a *menstruum* for the remedies employed, and it is the best, I think, that can be used in the treatment of diseases of the upper air-passages, for the following reasons: First, it is soothing, hence, non-irritating; second, it softens the hard, dry crusts of adhering mucus, and renders cleansing easier and more efficacious; third, it adheres to the parts and thus keeps the remedies in contact with the diseased structures longer and better than an aqueous solution can; fourth, it does not cause the fullness and unpleasant sensation in the head that is usually complained of when an aqueous medicament is used; fifth, it can be applied warm.

The various cleansing and astringent (or curative?) solutions that are generally used produce such pain and discomfort that they are never resorted to except when the annoyance and pain caused by the disease *compel* the sufferer to resort to something for relief. In these cases the "remedy is (almost) as bad as the disease." I have altered somewhat the formula used by Dr. R., of pinus canadensis, and use the following:  $\mathcal{R}$  Ext. pinus canadensis, 3 j.; acid carbol., C. P., gr. ijss.; glycerine, 3 vj.; aquæ fervens, 3 ij. M.

Of this mixture from one to three drops in half a dram of vaseline, "applied by means of such spray-producers as will make direct application to the *whole diseased surface*," used every other day, will soon relieve this trouble. I am frequently asked how I convert vaseline into a spray, it being a semi-solid? The answer is easy enough. First convert it into a liquid by heat. "The whole spray-producer should be made

warm, almost hot, by placing it over the gas or spirit-lamp, before the vaseline is put into the bowl. If this is not done the vaseline will not flow into the tubular portion of the instrument, consequently no spray will issue on passing compressed air through it." In order to mix the medicaments after they have been placed in the bowl of the instrument, "you simply place your finger lightly on the point where the spray comes out, and allow a small quantity of air to pass through the instrument. The pressure on the point turns a part of the air into the upper tube, which causes air bubbles in the bowl. The rising bubbles cause the two kinds of liquid to mix."

I spray, first, the vault of the pharynx; second, the post-nasal openings; third, the ant. nares, using the same medicament in each instrument.

2. *Hypertrophic Nasal Catarrh*. This is the most difficult and intractable variety of the disease with which we have to deal, a surgical operation (removing the hypertrophied membrane) frequently being necessary to effect a cure. After thoroughly cleansing the parts with the solution alluded to, I use, generally, glycerole tannin, two to six drops, in half dram of vaseline, in the same manner as in treating chronic nasal catarrh. When this does not produce the desired result, great good can be accomplished by using alternately either zinc chlor. or zinc sulph., one part to four of glycerine; of the latter from one to three drops in half dram of vaseline, and used in the same manner as above described.

I have obtained better results from the use of tannic acid, in the form of the glycerole, in the treatment of this form of catarrh, than from any other remedy. I have occasionally used with good results iodoform as recommended by Dr. Beverly Robinson, of New York,

by means of the insufflator, alternating this with the above mentioned treatment.

*Atrophic Nasal Catarrh.* In this form of the disease a detergent is always necessary in the beginning of the treatment. After thoroughly accomplishing this, use of *pinus canadensis* mixt. two to five drops, *eucalyptol* half drop, in half dram of vaseline, and spray the entire nasal and post-nasal cavities. I have found this combination to give very gratifying results in the majority of cases of this variety of catarrh. I have frequently had cases in which pulv. sanguinaria had a very good effect. This was used with the powder insufflator, according to the method and formula of Dr. F. Bosworth, of New York.

*Fetid Nasal Catarrh.* In this variety I make use of the same treatment as in atrophic nasal catarrh, increasing the *eucalyptol* to one or two drops, and using the iodoform powder once a week alternately, instead of the sanguinaria.

*Ozena.* This being a disease of the accessory sinuses of the nasal cavities, and due, as a rule, to syphilis or struma, the cause is first ascertained and if possible removed. The nasal cavities are to be kept cleansed, and the vaseline and *eucalyptol* used twice a week.

#### DISEASES OF THE URINARY ORGANS.

##### Of the Cause and the Nature of Diabetic Coma,

FRERICHS takes up and discusses in turn the various explanations hitherto advanced (*Boston Medical and Surgical Journal*): 1. Changes in the nervous centres. 2. Changes in the blood, viscosity from excessive sugar, change in the form and function of the blood corpuscles. 3. Uræmia. 4. Fat em-

bolism. 5. Acetonæmia. 6. Deranged elimination of the products of excretion. He considers all of these either disproved or unsupported as explanations of diabetic coma. He has been unable to verify in his autopsies the presence of fat emboli in the capillaries, and the term acetonæmia should, he thinks, be banished from pathology. The cause of death, he argues, is not the same in all these cases. In the cases included in the first group the cause of death is to be sought in the paralysis of the heart, brought about by the degeneration and destruction of the muscular fibres, whereby a rapid tissue transformation takes place, as shown by the presence of glycogen in the young muscle-fibres. In the cases of the second and third groups death is the result, evidently, of a process of poisoning or intoxication, the result of a series of slower or more rapid processes of transformation in the blood, the final products of which we are acquainted with, as acetone and *acetessigäure*, whilst the preceding steps of such processes are still unknown, and will be very difficult to detect on account of the ready and rapid changes which the materials of this series undergo. Frerichs designates the process simply as diabetic intoxication or poisoning, which is at once a declaration of negative knowledge and positive ignorance. Fourteen cases, of which four died with coma, four with phthisis, one with dysentery, were investigated histologically by Dr. Brieger with the utmost thoroughness. He found glycogen in various organs and tissues, but remarks especially upon its presence in the kidneys, not diffused, but strictly confined to a small belt of the parenchyma at the boundary between the cortex and the medullary portion, and this he regards as pathognomonic of diabetes.

**Iodoform in Diabetes.**

From the *Gaz. degli Ospitali* we learn that in two cases of diabetes mellitus Bozzolo has used iodoform (30 grains daily) with good results. In both cases the quantity of urine was decreased; in one (mild) the glycosuria entirely disappeared; in the other (severe) it was lessened.—*Med. and Surg. Reporter*.

**Uræmic Coma Hastened by Morphia.**

Dr. E. T. HUBBARD, of Madison, N. H., sends to the *Med. Record* the case of a man with Bright's disease, who had suffered with renal colic for fifteen years. He was given half a grain of morphia in the course of an hour, fell into a comatose condition, and died in three days.

**Nitrate of Amyl and Nitro-Glycerine in Uræmic Asthma.**

Dr. SHEEN, of Cardiff, furnishes the *British Medical Journal* with brief notes illustrating the value of nitrate of amyl and nitro-glycerin in one of the sudden and distressing, though perhaps rare, phases of chronic Bright's disease—viz., uræmic asthma. "Nitrate of amyl," he continues, "acting probably through the vaso-motor nerves, relaxes the arterioles and thus reduces blood pressure. As it is very volatile, on the score of economy and convenience, I always carry some of Martindale's capsules in my bag, and these are very handy for immediate use. Nitro-glycerin is said to have much the same action as nitrate of amyl, and, according to Dr. Mahomed, its great superiority over amyl lies in its gradual and more lasting effect, and the more convenient manner of prescribing it, and it can be taken regularly two or three times a day, or oftener, one minim of a one-per-cent. alcoholic solution being the usual commencing dose. It is also

made up in chocolate tablets, each containing one one-hundredth part of a minim; but its action when given in this form is not so rapid as that of the alcoholic solution."—*N. Y. Med. Journal*.

**Chronic Cystitis.**

Dr. DUNCASSE (*Gazette des Hospitaux*.—*N. O. Medical and Surgical Journal*) regards corn silk as par excellence the remedy in chronic cystitis, allaying the inflammation and facilitating the expulsion of gravel. So marked also is its anæsthetic properties in such cases that the writer thinks it must possess some alkaloidal narcotic substance. This anæsthetic action is not marked in acute cystitis. He quotes with approval the conclusions of Landrieux regarding stigmata maidis as follows: 1. Not only are the different preparations of stigmata maidis useful as a modifier of the secretions of the urinary passages, but these same preparations can be equally considered as an incontestible diuretic agent. 2. Diuresis is rapidly produced, and in three or four days the augmentation of the amount of urine becomes evident and considerable. 3. The diuretic effects are observed, not only in the organs of urinary secretion, but also in disturbances of the circulatory system (diseases of the heart and blood vessels). 4. The pulse is regulated, the arterial tension is increased, while the venous tension is diminished. 5. The medicament does not cause the least disturbance, either of the nervous system or the digestive functions. 6. Tolerance for this drug is complete and absolute, and medication in chronic diseases can be continued without inconvenience for a month or six weeks, according to my observations.—*Weekly Med. Record*.

CONSTITUTIONAL DISEASES.

**Acute Scoliosis.—Muscular Atrophy Following Typhoid Fever.—Rapid Amelioration.**

Lecture by M. DESPRES (*Union Médicale*):

You have seen in the wards a patient who has been electrized since a fortnight. I wish to call your attention to her, for we have here a case showing how true the theory of scoliosis is, as presented by Duchenne, of Boulogne, that illustrious physiologist who threw so much light upon muscular physiology and pathology.

A young woman, aged 20, married a few months only, had an attack of typhoid fever October 2d. The fever took on the abdominal form, was mild, was not accompanied by any grave cerebral symptoms, and only lasted about three weeks. The patient was in full convalescence, when her husband, she says, thought her waist was somewhat deviated. This gradually increased, and without the least suffering; at the time when the patient was presented to us, her characteristic aspect was striking.

The left hip projected considerably. I had the patient undressed immediately, as my diagnosis was formed. There was but one thing which could produce this projection of the hip—scoliosis. The right shoulder was prominent. The whole trunk was carried forward. The vertebral column had inflected itself progressively on the right side, describing a curve, with the convexity to the left in the dorsal region.

The lumbar region was normal yet. The affection was too recent for the compensating curve to have developed itself. It appeared evident to me that we had to deal with an amyatrophy of the lumbar vertebræ of the left side,

that is to say, on the side on which the abnormal convexity of the spine occurred. This atrophy, it could not be doubted, had closely followed the typhoid fever.

We know that in this infectious disease the muscles are altered; they present what has been termed a waxy degeneration, a degeneration which is but the first step toward complete degeneration. I have already published cases of abscess following the nutritive troubles known for more than thirty years; the consecutive deviations are certainly the consequence of these troubles, and are produced by locomotion, or simply by the lateral decubitus, prolonged more upon the one side than upon the other. To sum up, we have observed a deviation or acute scoliosis in a patient convalescent of a typhoid fever and having had no previous disease. The coincidence of the recent typhoid fever and of the scoliosis is so evident that it has the value of an experiment.

But the point upon which I wish to draw your attention almost exclusively is this: After a week's treatment, our patient is so much better that she is hardly recognizable. Everything warrants us in believing that a cure will be complete in a very short time. This proves to us that if we could treat in time, that is from the very beginning, cases of scoliosis, we would radically cure a great number.

The treatment which is to be applied in these cases may be summed up in a few words:

1. Faradization daily, or at least every other day.
2. Rational gymnastics.
3. Physiological prosthesis of the trunk by a special corset.

Of these three methods the first two only can prove curative.

In our patient :

1. The electricity was localized in the muscular masses corresponding to the convexity of the abnormal curve, that is to say, in the insufficient muscles. But, on the contrary, it was widely distributed, from the top to the bottom of the muscular masses, from the neck to the lumbar regions.

2. The indispensable gymnastic exercises were resolved into one motion, that of the trapeze ; that is, the elevation of the body by the strength of the arms. This method by lateral movements is less useful, as the patient will instinctively lean to one side or the other, and thus cheat.

3. As to corsets, they are apparatus good at the most when other methods of treatment have failed. The application of a corset is not even a method of treatment, as in reality it does not cure, but simply mars the deformity. True, the orthopedic corsets of Duchenne are constructed according to physiological laws, but despite this, their use is attended by little good ; the vicious position remains in all cases.

I will not speak of forcible straightening, proposed these late years. It is an ancient treatment resuscitated, and which, to-day as formerly, can only straighten those patients whom a methodical treatment, by electricity and gymnastics, has not cured.—*Weekly Med. Review.*

#### Transfusion of Saline Solutions in Acute Anæmia.

M. SCHWARZ, in a memoir published in the *Berl. Klin. Woch.* No. 40, 1882, arrives at the following conclusions after a very careful study of the subject:

Death, when ensuing on hemorrhage, is due principally to cessation of the circulation, and this sudden stoppage is due to the simple disproportion between

the size of the vessels and their contents, and not to an exaggerated diminution of the quantity of blood corpuscles.

The first indication then will naturally be to remedy this disproportion.

If ordinary means fail, recourse may be had to a very innocent method, yet one that has proven extremely sure and active; this is direct injection of feeble alkaline solutions (6 per cent.) of chloride of sodium into the circulatory system. The action of this transfusion on cardiac activity, blood-pressure, respiration, and all the other vital functions, has shown itself with surprising rapidity in rabbits and dogs who had lost from one-half to two-thirds of the entire quantity of blood contained in the body. The minimum quantity of liquid to be injected in the adult should be about five hundred cubic centimeters. This species of transfusion is also indicated in the serious collapse coming on during operations on the abdomen. Since the above conclusion appeared in the inaugural thesis of the author, five cases of transfusion of chloride of sodium solutions have been reported by Bischoff, Küstner, Kocher and Kummel.

Mr. Schwarz himself reports the following case: After an operation for the removal of uterine cancer, violent hemorrhage occurred. The woman lost consciousness, the face was cold, skin dry, pupils insensible, heart-beats feeble. One thousand cubic centimeters of solution of table salt was injected into the median vein. The result was prompt and favorable.—*Med. and Surg. Reporter.*

#### Effects of the Internal Administration of Glycerine.

Dr. TISNÉ speaks highly of glycerine as a therapeutic agent internally administered. He states (*Gazette des Hôpitaux*) that it causes no irritation

to the mucous membrane of the digestive tract beyond exciting a slightly increased peristaltic movement. It exerts a beneficial effect upon nutrition, increasing the weight and palliating many of the distressing symptoms in phthisis, such as loss of appetite, diarrhoea, night-sweats, and insomnia. Its action upon the liver is manifested by an increase in size of the organ and by a more abundant flow of bile. It has a diuretic effect and increases the excretion of urea, the chlorides, and the phosphates. The alkalinity of the urine is diminished, and if any pus be present in this fluid it is greatly lessened in amount.—*N. Y. Med. Journal.*

#### Fatal Purpura Hemorrhagica.

Dr. RONGON relates the following case in *L'Union Médicale*, No. 17, 1883: A naval officer, sixty-four years of age, had suffered for several years with glycosuria in a mild degree. In the summer of 1882 he received a severe shock in learning of the sudden death of his daughter. Other troubles weighed upon his mind and he became very despondent. Soon afterward he was seized with a profuse hæmaturia. This was followed by a deep hemorrhage in the scapular region. Purpuric spots made their appearance upon the abdomen and thighs. A few days later a sudden increase in volume of the right lower extremity was observed by the medical attendant, the left limb remaining of normal size. This was supposed to be due to hemorrhage, and the supposition was confirmed the following day by the discoloration of the skin. Hæmaturia and extravasations in various parts of the body continued until the death of the patient in syncope, thirty-seven days after the first symptoms had manifested themselves.—*Med. Record.*

#### The Feeble Influence of Iodine Over Malarial Fevers.

There have recently appeared numerous reports from medical men in various parts of the world, reciting the virtues of iodine in the treatment of malarial fevers. It is true that these do not all agree as to the exact degree of reliance that may be placed on this agent as an antiperiodic. There are, however, those who claim for it an efficacy not less than that of Peruvian bark, as far as the immediate control of the attack is concerned, and even greater than bark in preventing its recurrence.

It must be confessed, however, that the results reported by various observers do not entirely agree. Here we find an assertion that in chronic malarial poisoning iodine does its work most effectually; there, that its value is nil; in another article we find that it is recommended to render permanent the cure that quinine has begun; in still another, that it is given in combination with quinine, arsenic, etc. On the other hand, we find that by some anti-periodic properties are denied to iodine.

Attracted by the testimony in its favor, and with the desire to definitely ascertain the powers of iodine as an anti-malarial remedy, in view of the ease of its administration, and of its comparatively small commercial value, Drs. I. E. Atkinson and Hiram Woods availed themselves of the opportunity of treating malarial fevers afforded at Bayview Asylum, Baltimore, during the late summer and autumn of the past year (1882), and they record the results in the July number of the *American Journal of the Medical Sciences*.

Their experience leads them to draw the following deductions as to the use of iodine in acute malarial poisoning :

1. In intermittent fevers it has some

feeble influence in controlling the paroxysms.

2. It takes usually from three to eight days to exercise this influence.

3. In cures effected there is great danger of a relapse; certainly as great as with Peruvian bark.

4. It is certain to add to any existing diarrhoea or nausea, and is liable to cause each, if they do not already exist.

5. In remittents, its effect, if any, is seen in a slow and gradual reduction of temperature, and this reduction is liable to sudden interruptions.

6. In both forms of malarial fever it is infinitely inferior to either cinchonidia or quinine; certainly as regards the immediate control of the fever, and, as far as we are able to judge, as regards relapses also.

7. From an economic point of view, the slowness and uncertainty of its action make its use in hospital practice fully as expensive as Peruvian bark.

8. There seems to be ground to believe that it can cause albuminuria.

9. In the large majority of cases of ordinary acute malarial poisoning it has no influence whatever.—*Med. Age.*

#### Decoction of Lemons in Malarial Fevers.

Dr. MAGLIERI (*Gior. di Clinica e Terapia*) has obtained quite as good results with this simple remedy as with quinine. He finds it efficacious in acute and chronic malarial affections. Given four hours before the onset of a fever, it averts the paroxysm. This it did even in cases in which quinine had failed. In malarial cachexia the general health improved, and the liver and spleen were much reduced in size.

#### The Subcutaneous Injection of Nitro-Glycerine.

A correspondent of the *Medical Times and Gazette* writes that, by mistake, he injected thirty minims of a one per cent. solution of nitro-glycerine in a case of remittent fever, without any appreciable effects whatever. A subsequent examination revealed the presence of nitro-glycerine in the solution.—*Med. and Surg. Reporter.*

#### Another Substitute for Cod-Liver Oil.

Among the numerous substitutes for cod-liver oil which have from time to time been brought before the notice of the profession, dugong oil, which is an extract obtained from the dugong, an herbivorous cetacean inhabiting the warm seas of the coasts of Australia and the Eastern Archipelago, has met with a most favorable reception. Dugong oil is free from the unpleasant odor and taste which characterize cod-liver oil, and is much less liable to change in keeping. At ordinary temperatures it is opaque, from the separation of its more crystalline constituents, but becomes clear and almost colorless when slightly warm. The dose is the same as cod-liver oil.—*New Eng. Med. Monthly.*

#### DISEASES OF THE NERVOUS SYSTEM.

##### On the Pathology and Treatment of Certain Forms of Nerve-Weakness.

The following is a portion of a very able article by Dr. C. L. DANA, published in the *Med. Record*:

In discussing the subject of treatment I shall refer only to the treatment of the classes which I have described as the nervous, and the neurasthenic proper. It is intended not to go over the whole subject, but having outlined

certain general principles to call attention to some special measures with which I have had experience.

*General principles.*—The points of attack in the treatment of the neuropathies under discussion are: 1, the general condition of health and general nutrition of the body; 2, the nutrition of the nervous system and the neuromechanisms specifically; 3, specific medication; 4, the treatment of local sources of irritation, cerebral, spinal, gastric, intestinal, genito-urinary, vascular (this may include surgical measures); 5, mental treatment.

It is an accepted principle in the general treatment of most chronic neuropathic disorders that there should be two periods, one in which sedatives should be employed; in the other stimulants and tonics. A nerve made over-irritable by anæmia can be quieted by giving a drug which directly lowers the irritability, steadying the unstable molecules, or by enriching the blood and thus removing the irritant. It is found practically that often the sedatives and tonics can be given together.

Another most important principle in treatment is the necessity for change of therapeutic method. No drug and no special measure should be kept up continuously. There should be intermissions from all treatment if possible, and the disease should be successively attacked by various remedial agents.

A third important factor is the treatment by measures diverted to the afferent nerves, calling into play the reflex inhibitory and other mechanisms.

I present here the various therapeutic measures to be employed in the treatment of nerve-weakness in its general and localized forms:

*Hygiene.*—Muscular exercise, massage, Swedish movements, climate-cure, moist and warm localities, sea-voyages,

simple removal from ordinary surroundings. Mental hygiene: Amusements, change from ordinary tasks, the discipline of cures and special hospital establishments. Diet: Such as is best digested, slight excess of fats and nitrogenous food.

*Internal medication.*—Sedatives: Bromides, chloral, paraldehyde, hydrobromic acid, lupulin, camphor, scutellaria, cypripædia, digitalis, stigmata mais, valerian, gelsemium, conium, opium, cannabis indica, asafoetida, hydrocyanic acid, ergot.

Tonics and stimulants: Phosphorus, strychnine, arsenic, zinc, musk, ænanthic ether, caffein, thein, coca, salicin, quinine, alcohol. The various aromatic and simple bitters, mineral tonics, iron, act indirectly as tonics. Nitrous oxide.

*Surgical measures.*

*External medication.*—Tonic: *Electricity*—general electrization, faradic, galvanic, static, special electrization of intestines, urethra, sexual organs, spinal cord, brain. Nerve-vibration.

*Hydrotherapy.*—Tonic: Cold douches over body or spine, cool to cold baths, plain or medicated; sea or river bathing; acid, aromatic, and sulphurous baths; baths with stimulating friction, and use of oils, aromatics (myrrh, rue, savine, rosemary).

Sedative: Turkish or Russian baths; warm baths, 80° to 95°; hot baths, 95° to 120°.

*Revsives and Inhibitors.*—Blisters, seton, sparks of static electricity, hot iron, acupuncture, ignipuncture, aquapuncture; cold (ice-bags); heat. Moxæ.

*Regarding the sedatives* which may be used in nerve-enfeeblement.

The bromides here take the first rank. Every one is familiar with their value. Some statements about them, however, will bear repetition. They should be given generally in larger doses than is

ordinarily done, viz., gr. xxx. to gr. xl. or 3 j. The physician should understand that bromization is often the thing needed, not simply giving bromides. Bromization will secure therapeutic results, when simply giving bromides is of no effect at all. A convenient test for bromization is in many cases the production of faucial anæsthesia, so that the finger or a pencil can be thrust into the back of the throat without provoking reflexes. The bromization need not be kept up long, but may need to be repeated. It has seemed to me beneficial to put a patient through a "storm" of bromides just as is done in epilepsy.

Much larger doses of bromide can be taken and the drug can be kept up longer by giving digitalis, or cod-liver oil and iron, or coca at the same time. One patient who was only comfortable when nearly bromidized, felt less depressed while chewing coca leaves. A frail and somewhat anæmic patient of mine takes gr. xl. of bromide three or four times a day with iron, oil, quinine, and digitalis, and does not seem to suffer seriously from bromide depression.

The most powerful bromide is the lithium salt. But this is expensive and not always obtainable. Bromides are more powerful in combination, and one of the best combinations is, I think, that devised by Dr. Beard, and known as "Bromidi comp." The formula is as follows:

℞ Brom. sodi., brom. potass., brom. calc., āā gr. x. ; brom. lithiæ, gr. v. ; iod. potass., gr. ijss. ; Fowler's solution, gtt. ij. ; tr. capsici, gtt. j. ; aqua, q. s. ad. 3 j. M. Sig.: One dose.

Acne is to some extent prevented by drinking large quantities of water with each dose and by the addition of Fowler's solution.

If bromide of sodium be dissolved in carbonic acid water, 3 ss. to a tumbler

of the water, it makes a mixture very much like Saratoga Geyser, and New York ladies will drink it with much satisfaction. It is an improvement on the bromides with Vichy, as suggested by Dr. E. C. Seguin.

*Hydrobromic acid.*—For a year and a half I have been using hydrobromic acid quite extensively as a substitute for the bromides.

I find that it is a sedative like the bromides, that it does not produce acne nor constipation, nor does it often disturb the stomach. It may be substituted for the bromides in milder cases, even in treating epilepsy. It is convenient, because it can be given with iron, quinine, and other tonics. The objections to it are that in order to get powerful sedative effects one must give it in disagreeably large doses. The ordinary so-called Fothergill's solution has a strength of three per cent. of the pure acid, and it is altogether too weak to have much sedative effect. The doses which I usually employ are from ℥ xl. to 3 ij. of the ten per cent. solution. I have given 3 ij. four times a day without causing any but sedative effects.

With some persons the bromides do not act well. They will even increase irritability and cause insomnia. For these a very efficient sedative is one suggested by Dr. Beard, of which the formula is as follows:

℞ Fluid extract scullcap, fluid extract cypripedii, fluid extract blue cohosh, fluid extract lupulin, āā 3 j. ; fluid extract cannab. ind., 3 jss. Sig.: One drachm dose. The cannabis indica can be omitted.

The value of *ergot* is well known. It sometimes increases the sedative action of the bromides, especially when there is venous hyperæmia at the bottom of the trouble. In the insomnia occurring in certain cases of hypochondria, hyste-

ria, and melancholia, and in congestive headaches, it acts when even chloral and bromides fail.

Yet on the whole, ergot has not a very wide range of usefulness in chronic nerve-weakness, and its value, given alone, according to my experience, is not great.

*Caffein* is not generally considered a sedative, but in the first homœopathic dilution I have known it to relieve an obstinate case of insomnia with bad dreams. In other cases it has failed.

*Paraldehyde* is a new hypnotic recently introduced by Cervello, and tested in numerous cases by Morselli. It is claimed to be an excellent and safe hypnotic, acting like chloral upon the brain, but rather stimulating the heart. It seems to be a good hypnotic, perhaps not so powerful as chloral, except in disagreeably large doses. In two cases it appeared to have a general sedative and anodyne effect. A nervous, hysterical woman, who had been taking it, said she had not felt so well for a long time. The dose is from 3 ss. to 3 ij.

*Hyoscyamia* is not a very trustworthy drug, and need rarely be resorted to in the nervous troubles of the kind under consideration.

*The oleate of aconitia* and *aconitia* internally, but especially the former, are often very useful in relieving some of the neuralgic pains. Nothing special need be said about the other sedatives, chloral, cannabis indica, etc.

*Tonics and stimulants.*—Of the tonics and stimulants to the general system I have nothing especial to say. One of the best of the bitter tonics is salicin in rather large doses. A formula which is not particularly original is the following:

℞ Acid hydrobromic. dil., 10 per cent. or 3 per cent.; tinct. ferri muriat; acid, phosphor. dil., āā ʒ j.; strychniæ

sulph., gr.  $\frac{3}{4}$ ; salicin, 3 jss. Sig.: One drachm t.i.d.

The drugs which especially affect the nutrition of the nervous system are the following:

*Arsenic.*—In cases where the nervous troubles are kept up by a prostatic or urethral irritation the following formula was used by Dr. Beard:

℞ Liquor potas. arsenit., ℥ v.; tinct. cantharid., ℥ i-10; tinct. hydrastis, ℥ x.; tinct. nuc. vomic., ℥ x.; tinct. cannabis indica, ℥ x.; aquæ., q. s. ad 3 j. Sig.: A teaspoonful.

I have had prepared and used in several cases the liquor brom. arsenic, of Dr. Theo. Clemens, but have not been able to get any good results from it.

*Zinc.*—This may be given in a formula which includes a number of the zinc salts, as follows:

℞ Zinci bromid., zinci valerianat., zinci lactate, āā gr. j.; zinci phosphid., gr. 1-10; extr. belladon., extr. nucis vomic, āā gr. 1-5. Ft. one capsule.

The belladonna and nux vomica may be added or left off in accordance with the indications.

This combination is, I think, more efficacious than the single salt, yet I cannot say that I have used it often enough to speak dogmatically regarding it.

*Coca* is a very useful medicine if a good quality can only be got. It temporarily brightens up a patient. It is only palliative, however. Dr. Beard several times told me that it had greatly disappointed him.

*Caffein*, in my experience, has not been of much service as a nerve-stimulant.

*Damiana* I have been disappointed in. Dr. Beard told me he had found it of about as much value as so much water. Possibly samples differ. *Celerina*, in my opinion, is a humbug.

In the treatment of old-standing nervous disorders of the class in question, I have learnt that there is little to be expected from nerve-tonics. Only rarely is our work brightened by a meteoric success apparently due to these medicines alone, except the cases where there is anæmia or chlorosis, and where large doses of iron often act remarkably well.

*External medication.—Static electricity* has markedly helped cases of hypochondria, hysteria, and general nerve-weakness. It is not so useful, however, as other forms of electricity in most cases of nervousness and neurasthenia proper.

*General electrization* by the faradic and galvanic currents, it is well known, acts as a tonic to the nervous system and to the general nutrition of the body. My experience is that this electrization ought to be given oftener than is usually done, *e. g.*, every day, or even two or three times a day. This is the view also of many German electrotherapeutists. It is known that electricity by improving the nutrition allays irritability and acts as a sedative. But I think it is demonstrated that by the "polar method" and by special electrodes we can undoubtedly get specific sedative effects on the brain and cord at each application.

In cases of unilateral chorea I have in numerous instances applied a large stabile anodal electrode to the scalp over the region of the motor convulsions, the cathode is held in the hand of the opposite and affected side. A current of two to eight Stoeher's cells has been allowed to pass for about five minutes. In this way I have produced distinct amelioration in the choreic movements lasting for about 24 hours.

I have not had an opportunity of using anodal galvanism of the brain alone in cases of mental irritability and

weakness, but others have done so, and Althaus especially recommends the measure most enthusiastically.

In some forms of very severe chronic headache, strong anodal galvanization with the foot on the cathode will, I believe, prove beneficial.

I have had made a special electrode by which I can get the anodal effects upon the spinal cord. The spinal electrode is a long narrow sheet of brass, tempered so that its shape can be changed. This is covered with sponge. It is placed over the spine, covering the whole length, and the indifferent electrode held in the patient's hands. Before turning on the current the superficial or skin reflexes of the thorax are tested; then a strong current of twenty-five or thirty cells is passed, and the reflexes tried again. If the irritability of the spinal cord is really reduced by the anode, the reflexes, which are purely spinal would be less easily elicited. This has proved to be the case in some cases but not in others.

We have, I think, in electricity, an agent by which direct sedation of the over-irritable nerve-centres can be obtained. In a case of irritable sexual weakness with premature emissions, the patient after a few applications of my spinal electrode was greatly improved, though electricity had been tried before for a long time in vain.

I have here a special appliance for the treatment of sexual nerve-weakness. It was devised by Clemens, of Frankford, and was used upon a most obstinate case of impotence, a case which had been in the hands of many prominent neurologists in New York. The patient rapidly recovered and is now a new man. This, which I know to be a fact, is my excuse for showing the apparatus, which apparently has a good deal of hocus-pocus about it.

It consists of a zinc cylinder made to enclose the penis, with a funnel attached so that it can be filled with Rhine wine or weak alcohol. The positive pole is connected with it, and the negative pole, which is attached to a very large electrode, is placed over the spine. It is to be used three times a day for five or six minutes, a current of five to eight cells being employed. It is supplemented with a set of magnetic apparatus which seems to be of subsidiary importance. There is no doubt that the patient gets the sedative effects of the galvanic current very thoroughly. I am at present treating a case with it. The patient, who is a very intelligent man, in fact a doctor himself, was very decidedly improved, and is indeed now almost well.

*Hydrotherapy.*—As a *stimulant and tonic* we administer general cool and cold baths, medicated or otherwise; general tepid baths, gradually making them cooler; local baths of various kinds; cool and cold douches, hot douches or jets, and alternately hot and cold douches or jets; baths with massage or electricity.

*Cold baths* increase the oxidation of tissue and thereby act as a stimulus to nutrition. They increase the flow of urine. Reflexly they may relieve congestions and inhibit pains. Cold baths act as a tonic to irritably weak nerve-centres by thus relieving congestion, improving nutrition. Cold baths are invaluable to the nervous and neurasthenic when the general system is strong enough to react.

In sexual neurasthenia, with emissions, where the irritability is more prominent than the actual loss of power, cold sitz baths once or twice a day, or cold douches are indicated.

Cold douches to the back are of help to cerebral asthenia, with insomnia,

morbid fears, hypochondriasis. Persons who cannot endure cold baths at first can be made to do so by beginning with tepid or cool water, and gradually lowering the temperature. Medicating the baths with salt and alcohol, or aromatics, adds to their effect.

*Warm baths.*—These also may be local or general. Warm baths relax the blood-vessels, weaken the heart-beat, increase diuresis, lessen the amount of urine passed, act sedatively upon the nervous system. The sedation is that of exhaustion, however. Warm baths are to be used temporarily and intermittently, therefore.

I have known warm baths at night to help greatly in relieving insomnia. I have not known much benefit to come from Russian or Turkish baths.

Electrical baths furnish a good way to apply electrization. They are not in high repute among electro-therapeutists. In my very limited experience they have acted well.

*Revulsives and inhibitants.*—Of these, the cautery applied at the back of the neck and along the spine often gives excellent results in cerebral or sexual nerve-weakness. It stands at the head of counter-irritants.

After the cautery come blisters. Large blisters spread thin or in spots, so that they keep up a slight vesication for a long time, are one of the best forms.

Of the value of acupuncture, ignipuncture, the electric brush or moxa, the seton, I have nothing to say. If there is reason to suspect cerebral or spinal venous hyperæmia, counter-irritants ought to be freely used.

They are often also very potent in arousing dormant or enfeebled centres, or dispelling unpleasant symptoms, acting perhaps by reflex inhibition; I have, therefore, referred to them as "inhibitants."

*Dry cups.*—A patient of Dr. Beard's, who suffered from a most exaggerated anthrophobia, was treated for some time with little success. He went home finally, and being a mechanic, made himself a kind of air-pump with large cups attached. These he applied upon himself daily, and with the result of becoming almost well. Dr. Beard had one of these appliances made and had used it considerably. At the time of his death he had an article prepared giving his results. It had helped a number of cases, but by no means all. A patient of my own—a neurasthenic with hypochondriacal symptoms—dated his steady improvement from a systematic cupping which I gave him.

*Massage.*—Massage alone does not give much success. It is a luxury in therapeutics. Some neurasthenics cannot endure it. The *masseur*, if experienced, can tell after a few trials whether he can help the patient.

The *Weir-Mitchell treatment* by isolation, rest, massage, electricity, and overfeeding, is oftener applicable to women than men. The majority of male neurasthenics are, I think, not benefited by it, or, at least, will not submit to it. I believe that its good results are chiefly from the physical effects of a rigid system of eating and living.

*Diet.*—Dr. Beard, just previous to his death, had been studying the subject of food, and had written a chapter upon the philosophy of diet, based on the principles of evolution. In it he announced the following very original views :

"First, living beings feed on that which is below them in the scale of development.

"Second, the best food for man is that which is just below him or nearest to him in the scale of development.

"Third, food is difficult of assimilation for man in proportion to its distance below man in the scale of development."

#### Lumbago.

We quote the following by Mr. JAMES, from the *British Medical Journal* :

The successful results I have invariably found attending this system of treatment, which I have adopted for the last four years with my rheumatic patients, have decided me to give publicity to the course from which I have seen so much benefit derived. Its plan is simple enough. After preliminary dry-cupping over the seat of lesion, I inject subcutaneously ten minims of sulphuric ether, gradually increasing it till I have injected thirty minims (assuming I find no marked progress in the course of a week, of the treatment above named). I have found it advisable to precede this by a brisk purgative at the outset, and to administer a mixture containing five grains of salicylate of soda in an ounce of infusion of gentian, every two hours, concurrently with internal and external applications. In not one case have I yet found this curative system fail ; but, in about a week's time, usually, the patient is cured. Sufferers from lumbago have come to me nearly bent double with pains in the lumbar region, and have walked away erect and free from their distress after dry-cupping. I have seen sciatic patients come in limping, and go out free from the least indication. I can especially instance the case of one patient, an old man, who had been the round of all the London hospitals to no avail, for nine years previous to his consulting me. He had been given up by all as a hopeless case. On my asking whether he was willing I should try a method of treatment on lines hitherto unattempted, and,

on his consenting to the same, I pursued the system of subcutaneous injection already described, until I attained the administration of a drachm of sulphuric ether. Marked improvement followed this course, which I, however, was obliged to suspend, owing to the formation of a hard cicatrix over the seat of the sciatic nerve. Nevertheless, after this was removed, the patient ultimately found himself completely recovered; and during the five years which have elapsed since he first came to me, has sustained but one attack of sciatica, of a very slight character. I sincerely hope these few remarks on my own practical experience of this system of treatment of cases, the persistency of which so frequently baffles the efforts of the most experienced practitioners, may prove of some practical utility in similar cases.—*Weekly Medical Review.*

#### The Treatment of Delirium Tremens.

In spite of all that has been written on this subject, Dr. ATKINSON (*Practitioner*) thinks that sufficient attention is not given to the necessity of supplying the system with adequate nourishment. Certainly in the second stage, when the appetite is bad, the blood corpuscles deficient in quantity and shrivelled, and the brain anæmic and starved, it is useless to expect relief from sedatives unless the brain is at the same time supplied with the nourishment it requires. Death, no doubt, in *delirium tremens*, arises from want of sleep, but then it must be remembered that the want of sleep is caused by want of nourishment. The most important part of the treatment, then, is to improve the quality of the blood as quickly as possible by throwing into the system frequent supplies of light, nourishing and easily digestible food. The best way of ac-

complishing this end is by cutting off all stimulants and ordering half a tin of Brand's liquid essence of beef and half a pint of milk, to be taken alternately every two hours. As regards medicine, twenty-five grains of chloral with thirty minims of compound tincture of cardamoms in an ounce of water, taken every four hours, after the beef-tea, will be found most useful. Very little effect, though, is produced by the first dose of the chloral, inasmuch as the brain is without the nourishment it requires, but after the second dose the food begins to tell—some sleep, generally speaking, results, and this goes on increasing in proportion as the support is maintained. If nourishment is withheld, sleep disappears, and the old delirium returns.

By this treatment the patient is generally free from all delusions in about thirty-six hours, but good strong liquid food must still be taken for some days, though not quite so frequently. When there have been from ten to twelve hours more or less continuous sleep, then it is advisable to give up the chloral, and give thirty minims of the compound tincture of gentian with five minims of the tincture of nux vomica three times a day for about three days. This restores the tone of the nervous system and stomach and creates an appetite. A little tincture of euonymin may next be substituted for the nux vomica, and some Carlsbad salt may be given in the morning when required. By this treatment the duration of the delirium and the after-effects of the alcohol are very much lessened.—*Ibid.*

#### Hysterical Hair-Curling.

A very curious and unique case, which is denominated as above by Mr. LE PAGE, of Durham, England, hysterical hair-curling, is reported in the *Lancet*.

The history is suspicious, but the facts are well vouched for, as will be seen. The patient, aged seventeen, with a history of irregular menstruation, had felt ill with various neurotic symptoms, and a feeling of "pins and needles" over the scalp and general numbness of sensation. In the evening she washed her head in tepid water. After partially drying her hair with a towel (she did not approach a small fire which was in the room), and while so engaged in the presence of her parents, nearly the whole of the hair on the right side of her head drew up into a hard lump, and felt as if it would pull the roots out. Her father and mother were engaged until nearly two o'clock the next morning in the endeavor to untangle and straighten the almost solid mass, with but little success. The few ends combed out were spread on a pillow she then slept on; on awaking they found them drawn up as before. The hair on the left side of the head was quite smooth, very lightly waved, and not in the least tangled or drawn up. Viewed with the microscope, it was evident all the hairs which are contracted are flat, while those hairs which remain comparatively straight or looped and festooned are round. This disposed of a shadow of suspicion which naturally accompanies any unexplained phenomenon in a "hysterical" female. Viewed without the microscope, it was at once evident that no dexterity could have produced the condition of the hair. Mr. Le Page's hypothesis in explanation of the case is that excessive nerve-tension found vent in the pigmentary portion of the hair—viz., that some change analogous to electrolysis took place in the medullary portion, leading to chemical change, decrease of bulk, and contraction. Sir Erasmus Wilson regarded the condition as very interesting and

extraordinary, and, as never seen by himself, had desired and received permission to deposit Mr. Le Page's specimen in the dermatological department of the museum of the Royal College of Surgeons of England.—*Ibid.*

## DISEASES OF THE URINARY ORGANS.

### Suppression of Urine

Is a symptom not uncommon in the course of many diseases, but total suppression without previous ailment is very rare. A case of this kind, however, is related by Mr. DENIS D. DONOVAN, in the *London Lancet*, where both the kidneys failed to perform their function, and no urine was secreted for seventy-five hours. The patient was a man who had always enjoyed good health, and with the exception of an attack of syphilis twenty years previously, "which gave him very little trouble," he could not remember ever having been sick. For four or five days preceding his present trouble he had been drinking rather freely and not eating much, and on the morning of the day before sending for Mr. Donovan, he had experienced some trouble in passing his water, having a frequent desire to urinate, but voiding only a small amount. The last passed was at one o'clock of that day, the amount being about a wineglassful, of very high color. He had taken a teaspoonful of spirits of nitre to try and excite the kidneys to action, and also a glass of punch on going to bed to make him sleep, but did not succeed with either. His bowels were constipated, but there was no pain in the head or back. His expression was good, tongue furred and slightly red at the tip, pulse eighty, skin dry, temperature normal and no fullness or pain over the bladder or kidneys. A catheter was passed, but

no water came away, not even a drop being detected in the eye of the instrument. The treatment consisted of a purgative mixture of jalap, sulphate of magnesia and senna, with cream of tartar and mucilaginous drinks. Poultices of linseed meal made with infusion of digitalis were applied to the loins every four hours. The next day a jalap draught and a mixture containing squills, digitalis and spirits of nitre were ordered, also a hot bath, the patient to be wrapped in blankets afterwards. This produced a free action of the skin, but the kidneys were still inactive. Except of thirst, there was no complaint of any kind. A hot sitz bath was ordered, the patient to remain in it for an hour, and to have dry cups applied to the loins, and on account of his thirst he was allowed to drink a couple of pints of warm ale. At four o'clock in the afternoon, after seventy-five hours' total suppression, two ounces of very high colored urine were passed, and in about an hour afterwards twelve ounces were voided with a specific gravity of 1010, but containing no albumen. The secretion then became established, and in about a week he was at work feeling as well as ever. The theory advanced as to the cause of the suppression was, that it was due to extreme vascular congestion of the kidneys, paralysing their secreting powers, and caused most likely by alcoholic irritation and exposure to cold.—*Weekly Medical Review.*

#### Brain-Lesions of Traumatic Polyuria.

In a young man who had suffered a severe blow on the left side of the head and neck, temporary unconsciousness was followed by diplopia, which gradually disappeared, and by deafness in the left ear. He also developed inordinate thirst and polyuria. Upon exam-

ination, there were discovered the following morbid signs: complete paralysis of the left external rectus and slight paralysis of the right external rectus. In the left ear there was loss of perception of tones as such, and of power to distinguish them except when the tuning-fork was placed over the mastoid process. The watch could be heard the same on both sides. The quantity of urine was twelve litres (nearly twenty-six pints); neither sugar nor albumen was detected. Under the use of iodide of potassium internally and inunctions of mercurial ointment at the back of the neck, there was a decided reduction in the polyuria.

Dr. FLATTER, who reports the case (*Arch. für Psych.*, etc.), believes that the symptoms indicated the existence of an accumulation, possibly hemorrhagic, lying deeply in the medulla oblongata under the nucleus of the left external rectus, not only destroying the roots of this nerve, but also extending across so as to affect the nucleus of the right abducens as well. The cause of the peculiar difficulty of hearing, however, is not clear.

In the literature of diabetes insipidus and brain-injury it is of interest to note that two other cases (Kamnitz and Gayet) of paralysis of the sixth nerve have been observed accompanying diabetes.—*Central für die Med. Wissenschaften.*

#### DISEASES OF RESPIRATORY ORGANS.

##### Abstract of a Paper "On Nose-Cough and the Existence of a Sensitive Reflex Area in the Nasal Mucous Membrane."

Dr. JOHN N. MACKENZIE (*Md. Med. Jour.*):

The following conclusions are deduced by the author from his researches:

1. That in the nose, there exists a definite, well-defined sensitive area, whose stimulation, either through a local pathological process, or through the action of an irritant introduced from without, is capable of producing an excitation, which finds its expression in a reflex act, or in a series of reflected phenomena.

2. That this sensitive area corresponds, in all probability, with that portion of the nasal mucous membrane, which covers the turbinated corpora cavernosa.

3. That reflex cough is produced only by stimulation of this area, and is only exceptionally evoked when the irritant is applied to other portions of the nasal mucous membrane.

4. That all parts of this area are not equally capable of generating the reflex act, the most sensitive spots being probably represented by that portion of the membrane which clothes the posterior extremity of the inferior turbinated body and that of the septum immediately opposite.

5. That the tendency to reflex action varies in different individuals, and is probably dependent upon the varying degree of excitability of the erectile tissue. In some, the slightest touch is sufficient to excite it; in others, chronic hyperæmia or hypertrophy of the cavernous bodies seems to evoke it by constant irritation of the reflex centres, as occurs in similar conditions of other erectile organs, as, for example, the clitoris.

6. That this exaggerated or disordered functional activity of the area may possibly throw some light on the physiological destiny of the erectile bodies. Among other properties which they possess, may they not act as sentinels to guard the lower air passages and pharynx against the entrance of foreign bodies,

noxious exhalations and other injurious agencies to which they might otherwise be exposed?

Apart from their physiological interest, the practical importance of the above facts, in a diagnostic and therapeutic point of view, is sufficiently obvious; therein lies the explanation of many obscure cases of cough which heretofore have received no satisfactory solution, and their recognition is the key to their successful management.

#### Asthmatics and Catarrhal Subjects.

In a communication lately made by Prof. TRASTOUR to the Medical Society of Nancy, and published in the *Journal de Médecine de l'ouest*, he calls the attention of practitioners to the distinction that must be made between *true asthmatics* and *false asthmatics*—between asthmatics and those suffering from catarrh. If the true asthmatic may become afflicted with all the complications of chronic bronchitis, the false asthmatic (the catarrhal) may have veritable attacks of dyspnœa simulating asthma. In both, emphysema is most frequently present. In the true asthmatic, asthma alternates frequently with the diathetic manifestations which it excites (arthritism) herpetism; it comes on by sudden attacks under the influence of changes of locality, of dust, of odors, etc. Besides, we find in the asthmatic emphysema more or less marked, little dyspnœa, cough or catarrhal susceptibility. The false asthmatics have also their balance of conditions, hereditary or acquired. They may have attacks of dyspnœa resembling very greatly (as to be mistaken for them) attacks of asthma; but outside of these attacks they remain valetudinarians, and it is these morbid conditions, as variable as the individuals themselves, which

must be discovered and modified in order to change the unfavorable prognosis made of asthmatics as a class who have passed the adult age. Outside of the paroxysms, the true asthmatic enjoys good health; the catarrhal subject, the false asthmatic, is still sick. Prof. Trastour studies the morbid conditions of the last-named, the chronic bronchitis and the cardiac pulmonary lesions. Of the three elements constituting asthma, the nervous, organic and secretory, it is the last which predominates in catarrhal subjects. The nervous susceptibilities are less in him; the paroxysms of dyspnœa are less sudden, not so well marked, but, on the other hand, the oppression is habitual. In the true asthmatic, treatment must be directed against the diathesis; the prognosis is by so much the more favorable as the paroxysms appear at greater intervals and the emphysema less pronounced. But when true asthma is complicated with chronic bronchitis, the difficulty of diagnosis is great, and can only be supported by the history of the case. Here you have a case where the same indications present themselves for prognosis and treatment in these two classes of patients. Prof. Trastour gives the treatment which has given the best results in catarrhal asthmatics and asthmatics who have become catarrhal. There are four indications to be fulfilled: 1st. *The circulation to be modified.* Bloodletting (except in true asthma), evacuations. 2d. *To diminish morbid secretions.* Revulsives, vesicatory, dry friction daily, etc. 3d. *To combat chronic inflammation.* The author mentions more especially iodine in solution, iodo ioduree and the iodine of calcium. 4th. *The nervous system to be controlled.* Antispasmodics and sedatives; above all, morphine. With this ensemble of means, the catarrhal respire more freely, do not suffer so

much from oppression, expectorate less, the rhonci disappear, and the condition of the heart becomes consecutively ameliorated. According to Prof. Trastour, the use of the iodine preparations should be continued for months and years.—*Gazette Medicale de Nantes*.—*Cin. Med. News*.

Misce, fiat mistura, cujus sumatur cochleare magnum ex aquâ ter die semihorâ ante cibum.

Where there is a deficiency of glandular secretions, generally, throughout the intestine, manifested by a peculiarly dry and earthy character of the dejecta when the bowels *do* act, he gives:  $\mathcal{R}$  Aluminis,  $\mathfrak{z}$  iij.; tincturae quassiae,  $\mathfrak{z}$  j.; infusi quassiae,  $\mathfrak{z}$  vij. Misce, fiat mistura, cujus sumantur cochlearia duo magna ter quotidie, post cibum.

The third form, which depends chiefly on interruption of the natural habit of periodic discharge, often results from repeated failure to move the bowels, in consequence of one or other of the two preceding forms of this trouble. This may generally be relieved by directing a perfectly regular attempt to go to stool, and by the use of the following draught, taken the first thing after *rising* from bed—not on awaking—in the morning, as nearly as possible at the same hour. It will be observed that it is not an aperient in the ordinary sense of the term. It is, as a rule, neither necessary nor desirable to continue it for longer than a fortnight. In most instances, it will be found to re-establish the normal habit in a week or less.

$\mathcal{R}$  Ammoniae carbonatis,  $\mathfrak{z}$  j.; tincturae valerianæ,  $\mathfrak{z}$  j.; aquæ camphoræ,  $\mathfrak{z}$  v. Misce, fiat mistura, capiat partem sextam in modo dicto.—*Med. and Surg. Reporter.*

#### Swallowing of Shot and Insufflation in the Treatment of Ileus.

From the *London Med. Record* we learn that in three cases (*Gaz. Med. Ital. Lomb.*), with well-marked symptoms of invagination of the bowel, obstinate constipation, stercoraceous vomiting, pain, etc., Dr. PEDRINI, after other remedies had failed to relieve, made the patient swallow five or six

bullets and two kilogrammes of No. 3 shot, at the same time using prolonged and repeated insufflation of air by the rectum. In each case the success of this treatment was complete, relief being quickly obtained and the patient making a good recovery.—*Ibid.*

#### Diet vs. Diabetic Coma.

In the report of a very interesting case of diabetic coma in the *Brit. Med. Jour.*, Dr. J. W. BOND says: "It is somewhat surprising that, in the published cases of diabetic coma, little is said as to the diet. In this, as in two other cases of which we have exact information, diabetic coma has supervened on the adoption of a diet rich in albumen and poor in starch. We think it noteworthy that the addition of extra mutton to a generous albuminous diet, in the case just described, was accompanied by an increased daily passage of over forty ounces of urine. On the first day after this increase of diet, the amount of urine rose from ninety-six to one hundred and sixty-eight ounces."—*Ibid.*

#### Jaborandi in Jaundice.

We recently had a most obstinate case of jaundice, in which the usual remedies proved unavailing. We finally prescribed 30-drop doses of fluid extract jaborandi, with a view of relieving the circulation of the presence of bile through the skin. The sweating was profuse and great relief was afforded. The liver gradually resumed its action aided by cream-tartar, podophillin, extract taraxacum, etc. We attribute the starting of the function of the liver entirely to the action of the jaborandi.—*The Southern Clinic.*

CONSTITUTIONAL DISEASES.

Various Prescriptions.

The man who commands the largest practice in Philadelphia, and who is at the same time the favorite lecturer on clinical medicine, is Prof. Pepper, of the University. He hardly ever delivers a lecture that is not published. They tell me he makes up by never writing an article, probably because he lacks the time. The way the doctor thumbs around on patients and brings out the points here and there is astonishing. Nothing but an immense experience and a close observation of disease could have given him his accurate knowledge. We pumped him on his way from the wards to the amphitheatre, on typho-malarial fever. Dr. Pepper does not believe there is such a disease. He thinks that cases thus diagnosed by practitioners were either typhoid fever, with some malarial symptoms, or simple continued fever. He believes that physicians have confounded complications occurring in cases of disease with disease. Typho-malarial fever, so-called, is no more a distinct disease than is typho-pneumonia. It should be treated as typhoid fever, and the complications are treated as such, just as they are when occurring in pneumonia, bronchitis, dysentery, etc. And the doctor nodded his head and passed into the amphitheatre. He had crushed a favorite idea of mine, and I take revenge by hurling the lesson at the heads of some of my western brethren.

Dr. E. T. Bruen is Prof. Pepper's assistant, and is preparing himself to fill the Professor's shoes in the future. He is connected with the dispensary of the Children's Hospital, where he gives instruction to graduates. At several of the meetings I gathered some good points, which are here presented.

A case of whooping-cough in a boy four years of age presented symptoms of an acute attack of the disease. Dr. Bruen prescribed: *R.* Bromide quinine, grs. xvi.; syrup gum arabic, fl.  $\frac{3}{4}$  j.; syrup ginger, fl.  $\frac{3}{4}$  j. *M.* The patient was ordered to take a teaspoonful of the medicine four times a day. If no relief was experienced, it was to be increased. The mother was directed to prick a hole with a pin in a piece of paper every time the patient had a severe attack of cough during the day. She then compared the holes made on the different days, and if they did not diminish she increased the doses of the medicine up to eight teaspoonfuls a day. As the holes decreased she was to give fewer doses.

A little girl, nine years of age, suffering with obstinate malarial fever, was ordered to take half-drachm doses of cream of tartar, dissolved in water, twice a day. Dr. Bruen thinks that the cream of tartar assists quinine in its action as an antiperiodic.

In a case of mucous diarrhœa in a child of one year of age, Dr. Bruen prescribed what he called his favorite prescription: *R.* Bismuth subnit. gr. lx.; fl. ext. rhubarb, gtt. viij.; syrup blackberry, fl.  $\frac{3}{4}$  ss.; elixir orange, fl.  $\frac{3}{4}$  ss. *M.* Of this the child was ordered to take a teaspoonful four to six times a day. Proper feeding—barley-water, milk and limewater—was also directed. Starchy food was positively prohibited.

A little girl, ten years of age, was afflicted with tuberculosis of the lungs. She was pale, emaciated, and harassed by a cough. Dr. Bruen prescribed: *R.* Olei morrhue, fl.  $\frac{3}{4}$  j.; syr. calcii lactophosphatus, fl.  $\frac{3}{4}$  ij.; syr. ferri iodidi, fl.  $\frac{3}{4}$  j.; liquor calcis, q. s. ad. fl.  $\frac{3}{4}$  iv. *M.* Sig. A teaspoonful three times a day after meals. As an embrocation, equal parts cod liver oil and soap liniment were

ordered. The patient was to wear warm flannels and take out-door exercise. For the cough:  $\mathcal{R}$ . Acid. sulphuric dil.,  $\mathfrak{M}$  xvj.; tr. opii deodorat,  $\mathfrak{M}$  viij.; syr. pruni virgin, fl.  $\mathfrak{z}$  j.; aquæ, fl.  $\mathfrak{z}$  ij.;  $\mathcal{M}$ . Sig. A teaspoonful or two, every two or three hours.

A case of diphtheria in a child two years of age was given:  $\mathcal{R}$ . Tr. ferri chloridi, fl.  $\mathfrak{z}$  ss.; acid. acetici dil., fl.  $\mathfrak{z}$  j.; liq. ammon. acetat, fl.  $\mathfrak{z}$  j.; syrupi, fl.  $\mathfrak{z}$  ij.  $\mathcal{M}$ . Sig. A teaspoonful three times a day. To be applied locally with a camel's-hair pencil;  $\mathcal{R}$ . Comp. tr. benzoin, fl.  $\mathfrak{z}$  ss.; carbolic acid, gtt. x.; glycerin, pure, fl.  $\mathfrak{z}$  jss.  $\mathcal{M}$ .

The liniment most frequently prescribed by Dr. Bruen for his dispensary patients is one cupful of vinegar, a half cup of turpentine, and the white of an egg well beaten together. As a stimulating liniment to the chest for pneumonia and bronchitis in children, this is excellent. His favorite antiperiodic in these cases is the citrate of iron and quinine. This is also often prescribed as a tonic in anemic conditions where malaria seems to be the cause.—*Cor. Louisville Med. News.*

#### The Biological Action of Picrotoxin.

Professor CHIRONE, of the University of Padua, published last year his experimental researches on the biological action of cinchonidin. He found this alkaloid was capable of producing a true artificial epilepsy. By means of many vivisections he was able to demonstrate that cinchonidin exercises its action on the cortical motor centres of the brain; since, when the cerebral hemispheres in pigeons were removed, the epileptogenic action was wanting; when one cerebral lobe only was removed, cinchonidin caused an epileptic convulsion only on the half of the body in re-

lation with the psycho-motor centres not removed.

Picrotoxin also is able to produce epileptic convulsions. Professor Chirone now publishes the results of his experiments with picrotoxin, undertaken with the aid of Dr. Testa, and compares the action of picrotoxin with that of cinchonidin. He says:

1. Cinchonidin produces a less complete convulsion, since the motor muscles of the eye, the tongue, and the bladder, are rarely affected, while these are always involved with picrotoxin.
2. The convulsion caused by cinchonidin is at first clonic, afterward tonic; while with picrotoxin it is at first tonic, afterward tonic and clonic.
3. By cinchonidin those muscles which are most used in the normal life of the animal are most affected; while by picrotoxin the muscles of the back and neck suffer most.
4. Cinchonidin does not cause convulsions in rabbits, even in a poisonous dose, while these animals are very susceptible to the action of picrotoxin.
5. Cinchonidin has no convulsive action in hibernating animals (frogs, lizards, and toads), while picrotoxin causes violent convulsions.

From these and many other facts the authors came to the conclusion that picrotoxin has not the same seat of action as cinchonidin, and that it provokes convulsions by other mechanism. Picrotoxin acts on the medulla oblongata, since it determines epileptic attacks in decapitated frogs and pigeons whose brains have been removed, and these attacks are even more intense. These are the conclusions at which they have arrived:

1. Picrotoxin may determine true epileptic attacks. These attacks may be very complete, preceded by cry. They commence ordinarily with tremors of the head or contractions of the muscles

of the face, and are progressively diffused through the whole organism. There is loss of consciousness; the animal falls; there are abundant salivation, tonic and clonic convulsions, loss of urine, convulsive rolling of the eyeballs, convulsion of the tongue, which is often bitten, arrest of the respiration and heart. 2. Convulsions from picrotoxin are independent of the psycho-motor centres, since they are more intense when these are removed. 3. Picrotoxin displays its action first on the bulb and on the parts connecting the cerebral and spinal centres, then on the spinal centres, by the last action resembling quinine and differing from cinchonidin. 4. Picrotoxin brings into relief a functional antagonism between the psycho-motor centres and the motor centres of the medulla oblongata and spinal chord. 5. Picrotoxin can also give rise to convulsions after the medulla oblongata is removed. This conclusion is deduced from the experiments on frogs, and in this case the convulsion is later and is tonic. 6. The convulsions of the limbs due to picrotoxin depend on the action which is displayed on the medulla oblongata, and is propagated by the spinal cord, and, secondly, by the direct action of the spinal centres. 7. In frogs the spinal functions are more developed than the cerebral, and, *vice versa*, in dogs and other higher mammals the cortical motor centres of the brain are more developed than the spinal centres. 8. The convulsions due to cinchonidin are of cerebral origin, and are not obtained when the psycho-motor centres are removed. The convulsions due to picrotoxin are of spinal or bulbar origin, and are more intense after the removal of the higher centres.—*London Medical Record*.

**Position in the Treatment of Diseases.**

C. R. ILLINGWORTH, M. B. (*British Medical Journal*): In the treatment of cases of bilious vomiting, I have found attention to position a very important element. I place all patients suffering from this complaint on the right side, in order to facilitate the exit of the contents of the stomach through the pyloric orifice. This treatment alone, in many cases, suffices to stop an attack, and, combined with the usual remedies, it is very successful. The same position is also good in threatened attacks of the passage of gall-stones, which may thus sometimes be averted, presumably by the action of gravitation upon the dislodged stones. The question of position is, in fact, in my opinion, an important one to study in the treatment of various affections and natural processes. Much has been written, for instance, about the position to be insisted upon in the several complications of midwifery practice; but great difference of opinion still prevails as to the best position for natural labor. As securing the greatest amount of ease and "purchase" to the parturient; the greatest facilities for the expulsion or extraction of the placenta; the least risk of hæmorrhage; and the facilities afforded for the application of the forceps and manipulations generally, I prefer the kneeling posture.

After parturition, the question of displacements of the uterus, and their prevention, has to be considered. I am led to believe that retroversion is caused, not so much by "getting up" too soon after labor, as by continually lying upon the back. I take care to caution patients against the adoption of that position for some time after labor, and invariably allow them to rise as soon as they feel able to walk.

Position may also be studied with advantage in the third stage of a pneumonia,

to facilitate discharge through the bronchi; in phthisis, also, in the emptying of vomicae.

Having for many years been of opinion that incubus is due to venous congestion of the cerebellum and medulla, caused by lying upon the back for a length of time during sleep, I advise that vigorous efforts should be made by the patient to turn the head, if only slightly, upon one or other side, and thus allow the delayed venous current a free passage from the torcular herophili to the jugular fossa of that side.

A great deal might be said in reference to this subject in its bearings upon other departments of medicine. What I have written, however, may suffice to indicate the desirability of a thorough ventilation of opinion upon it.

#### **The External Application of Salicylate of Soda in Acute Rheumatism.**

Mr. WHITELEY, in the *Lancet*, gives short notes on six cases of acute rheumatism, which benefited greatly from the external use of a lotion of salicylate of soda to the affected joints. The strength of the solution varied from 15 gr. to 20 gr. to the ounce. To those joints to which it was applied, relief followed very quickly, while those joints to which it was not applied were not relieved like the others.

#### **Ol. Gaultheria in Rheumatism.**

At a meeting of the New York Medical and Surgical Society, Dr. FLINT said that one of the house physicians at Bellevue Hospital had furnished him with the following statistics with regard to the use of gaultheria in that institution in cases of articular rheumatism (*New York Med. Jour*): Of thirteen cases thus treated of which the histories were given, one patient contracted pneumonia

after the cure of the rheumatism, and died in the hospital; a second one remained in the hospital, at the express wish of the commissioners, some time after cure of the remaining eleven cases; the longest duration of the disease in any one case was fifteen days, and the shortest two days. The average length of time the eleven patients remained in the hospital was a fraction less than five days. These figures would seem to point to rather better results from the drug than those which were ordinarily obtained from salicylic acid. The oil of wintergreen was the preparation used, and it was administered several times a day in ten-drop doses in flaxseed tea, which made it less disagreeable to the taste and to the stomach. In some of the cases the alkaline treatment was employed at the same time with the gaultheria.

#### **Articular Rheumatism.**

The following formula is recommended by Dr. F. E. STEWART (*Medical Bulletin*) in the treatment of acute articular rheumatism: Salicylic acid, 3 ij., divided into three powders and wrapped in white paper; potass. bicarb., 3 vj., divided into three powders and wrapped in blue paper. The contents of one blue and one white paper mixed together in a tumbler, with a little water, are given three times a day until nine powders have been taken. He says, if no marked benefit is produced at the end of three days, it is useless to continue the remedy.—*Weekly Med. Review*.

#### **Facial Erysipelas.**

The following (for facial erysipelas) may be painted over the parts affected once every two hours, a thin layer of cotton being placed over the parts immediately afterwards: R̄ Ac. carbolic, sp.

vini rect., āā, 3 j.; sp. terebinth, 3 j.;  
tr. iodinii, 3 j.; glycerine, 3 v. M.

**Borax and Glycerine in Erysipelas.**

In the *Medical Times* (Phila.) will be found an article on the treatment of erysipelas, in which the writer recommends the local application of borax dissolved in glycerine in the strength of one drachm to the ounce, and applied on linen. The writer speaks from an experience of eight years, and claims that it cuts short the disease in a remarkable manner.—*Canada Lancet*.

**Treatment of Diphtheria by Cold Water.**

Dr. WORTHINGTON, in *Canada Lancet*, thus concludes an interesting article on this subject:

1st. The treatment of diphtheria must be begun with the invasion of the disease to secure any safety to the patient—not a moment's time should be lost. 2d. The cold water applications should be made on the first appearance of a rise in temperature, and its continuance governed by a tendency of the extremities to become cool. 3d. The most careful attention should be given to the nourishing of the patient from the first. 4th. Adynamic symptoms should be anticipated by the free use of stimulants and tonics, and the application of artificial heat if necessary.

**Chlorine Water in Diphtheria.**

Dr. CAROLINE R. CONKEY, of Watertown, N. Y., sends us a very enthusiastic description of the value of chlorine water in diphtheria. She writes: "In a late number of the *Medical Record*, Dr. Binz, of Bonn, is quoted as predicting that a remedy would surely some day be found which should prove as ef-

fectual a specific antidote to diphtheria as salicylic acid and quinine are to rheumatism and malarial fever. Such an antidote, I believe, we already possess in chlorine water.

"The importance of this agent was first brought to my notice by Dr. Marshall Calkins, of Springfield, Mass., to whom, I believe, the credit of discovering this application of chlorine water is due. Since then I have used it with unfailing success in every case of diphtheria that has come under my notice; and claim its absolute efficiency in curing the disease, provided, always, it can be dealt with in the first stage, *i. e.*, before the membrane extends into the larynx. My plan of treatment is as follows: Fresh chlorine water must be made every day according to the following formula: R. Potass. chlor., 3 ij; acidi muriatici, 3 j; aquæ, 3 viij. Into an eight-ounce bottle put the chlorate of potash; on this pour the acid, and cork as quickly as possible to prevent the escape of the gas. Add the water as hot as convenient, at intervals. Dose: tablespoonful in an ounce and a half of water, to be gargled and swallowed every half hour in a severe case.

"This dose may be swallowed without gargling if, for any reason, that is impossible, and may be sweetened to render it palatable to a child. The interval between the doses may be lengthened, according to the discretion of the physician; in milder cases, being given every one, two or three hours, as indicated. When the membrane extends into the nose or posterior nares, syringe with the same solution.

"This constitutes my entire treatment, and its success is invariable. I insist upon the most nutritious diet. Every two hours, nourishment in some form is given; and an even temperature of about 70° F. constantly main-

tained in the sick chamber, together with the most thorough ventilation.

#### Salicylic Acid or Quinine.

Dr. SCHILLING recommends in the *Allgem. Med. Central Zeitung* the administration of ergot in conjunction with salicylic acid or quinine (*Medical Record*) to obviate the unpleasant effects of those drugs. In cases where large doses of salicylate of soda had produced congestion of the external auditory canal and membrana tympani, he had found that the use of ergot was followed in every case by a cessation or marked diminution of the tinnitus and deafness. The dose of ergot, which should be the aqueous extract, is about one-tenth that of the salicylic acid, the antipyretic effect of which does not seem to be influenced by the ergot. Similar results were obtained by combining ergot with quinine.—*Weekly Med. Review*.

#### Diphtheritic Erythema

Has been observed in quite a number of cases by Dr. A. R. ROBINSON (*Jour. Cutaneous and Venereal Diseases*), and he regards the affection as angioneurotic in character. The skin becomes affected, either in the early stages of the disease or at a late period in some severe cases of blood-poisoning. A diffuse erythematous rash of variable extent appears at the commencement of diphtheria or upon the second or third day. It may occupy the whole body or only a portion. It is rarely seated upon the head. In color it is from a bright-red to a pale-red. In some cases the rash is not a diffused erythema, but presents a mottled appearance, normally colored skin alternating with pin-head sized erythematous spots as in many cases of scarlatina. The redness easily disappears upon pressure. There is no eleva-

tion of temperature, burning or itching. It is met as often in mild as in severe cases of diphtheria. The only eruption with which it might be confounded is scarlatina, and sometimes the difference can only be established when desquamation is observed or not. When the erythema is due to septic poisoning it is generally limited in extent, and commences as pin-head sized or larger erythematous raised spots of a bright red color, and has a great resemblance in general to erythema multiforme. It neither itches nor burns, nor does it desquamate. Occasionally it leaves a slight brown pigmentation. In fatal cases the eruption continues until death; new spots frequently arising, or the old ones, after reaching a certain size, remaining as elevated rings or patches. The appearance of the eruption generally signifies a fatal termination. The author has observed about one hundred cases in which the early rash appeared, and about thirty in which the septicæmic variety was present, and all of the latter presented the character of erythema multiforme, this being also the experience of Prof. J. L. Smith.—*Weekly Med. Review*.

#### Gargle in Diphtheria.

R Potass. chl., ʒ ss.; tr. ferri chl., ʒ ij.; spts. ether, nit., ʒ ss.; glycerine, ʒ j.; aquæ ad., ʒ ij. M. Sig.: ʒ j. as gargle.

#### Beef Tea.

Dr. RIDGES gives the following directions for preparing an article, which really is what it purports to be, and far superior to any of the so-called extracts of meat:

1. Take one pound of lean gravy beef, and cut it into pieces as small as possible. A sausage-machine will accomplish this most thoroughly, and thus

save half the time of step No. 5, while it will enable you to extract all the goodness of the meat more thoroughly.

2. Place the meat in a preserve jar with one salt-spoonful of salt, and put the jar in a saucepan sufficiently large to allow the lid to be placed on when the jar is in it.

3. Mix in a large jug equal quantities (carefully measured) of boiling water and cold water.

4. Put a half a pint of this mixed water into the jar which contains the meat, and pour sufficient of the remainder into the saucepan outside the jar to reach as high as the water inside the jar, then put the lid on the saucepan, and place it on the hearth, not on the fire or on the hob. It will do no harm to cover the saucepan with a cloth or anything which will keep in the heat.

5. The meat must remain in the jar from three-quarters of an hour to two hours, according to the fineness to which it has been chopped, being stirred every quarter of an hour. If cut into pieces a little smaller than dice, one hour and a half will be sufficient. At the end of this time take out of the jar and strain through a hair sieve, or through muslin, with gentle pressure.

6. Place the red meat juice thus obtained in a small saucepan, and heat it to boiling while you stir. It will turn brown, and curdle. Strain off the solid flakes, and rub these thoroughly with a small teaspoonful of arrowroot or corn flour, then boil these again five minutes with the liquor which was strained off, and set it on oneside for the present.

7. Now take the meat which was left in the sieve at the end of step No. 5, and put it into a saucepan with a quart of boiling water, cover, and let it simmer over a slow fire for three hours; then allow it to boil and strain immediately.

8. Now boil this strained liquor down to half a pint.

9. Then mix this half pint with the half pint left at the end of step No. 6, and you will have one pint of strong beef tea containing all the soluble portion of the meat.—*Druggist*.

#### Therapeutical Notes.

*Action of Mixtures of Air and Vapor of Chloroform; a New Method of Anæsthesia.*—M. PAUL BERT (*Gazette Hebdomadaire de Médecine et de Chirurgie*) has found that if a dog be made to breathe a mixture of 4 grammes of chloroform, vaporized in 100 litres of air, the animal remains conscious throughout the whole of the experiment, which was prolonged in one case to a period of nine hours and a half. In this case the rectal temperature fell to 35° C. [95° F.]. With a mixture of 6 grammes of chloroform vaporized in 100 litres of air, death took place in about seven hours, with a temperature of 31° C. [88° F.]. Consciousness remained throughout, though it was impaired, especially during the last hours, when the animal was very cold. With a mixture of 8 to 100, insensibility of the skin and even of the cornea took place, very gradually, however, and after a period of excitement. Death occurred at the end of six hours, the temperature being reduced to 30° C. [86° F.]. With 10 to 100, insensibility supervened in a few minutes. The sleep was absolutely quiet, and death resulted without any stage of excitement, in from two hours to two and a half. The temperature was then from 35 to 33° C. [95 to 91.5° F.]. With 12 to 100, speedy insensibility without excitement; death in an hour and a quarter; temperature 35° C. [95° F.]. With 14 and 16 to 100, death in three quarters of an hour; temperature, 38° C. [100.5° F.]. With 18 and 20 to 100,

death in half an hour. With 30 to 100, death in a few minutes. In all these experiments tracheotomy had been performed upon the animal. The chloroform was perfectly pure.

The experimenter calls particular attention to the following facts:

1. Whether death supervened quickly or slowly, the heart always continued to beat after the cessation of the respiratory movements.
2. Even after an anæsthesia of several hours, no chloroform appeared in the urine.
3. When the proportion of chloroform was very small, an enormous amount of it was inhaled without causing any objective phenomena except the lowering of the temperature.
4. With a slightly greater proportion of the anæsthetic, life was slowly destroyed. There was great lowering of temperature, but consciousness persisted until life was extinct. Furthermore, the chloroform acted only on the nutritive processes, probably by producing torpor of the ultimate cells, as the cells in beer were made dormant in the experiments of Claude Bernard.
5. With still greater proportions of the anæsthetic, when unconsciousness comes on quietly, death is always the result of the continued inhalation of the chloroform mixture. The stronger the mixture the more quickly does death take place, and the less the temperature is lowered. A dog was made to inhale a mixture of 12 grammes of chloroform to 100 litres of air. At the end of some minutes, when he was well anæsthetized, he was given a mixture of 8 to 100. This, which if used from the beginning, would cause unconsciousness very slowly, and only after a stage of much excitement, was quite sufficient to continue the action of the stronger mixture. As it is not fatal unless administered a very long time, it rendered it possible to continue the anæsthesia perfectly for more

than three hours without any danger to life, and without embarrassing the respiration or circulation. The temperature alone was affected. This is a very simple proceeding, and requires nothing but the use of two caoutchouc bags and two gasometers.

Before these facts are applied by surgeons, it remains to be determined of what strength anæsthetic mixtures should be made, to produce on human subjects the same effects as those in the foregoing series of experiments upon dogs.

#### Apoplexy.

Dr. J. R. GORRELL thus concludes an interesting article in the *Iowa State Med. Reporter*:

The treatment in my hands will consist of the use of remedies that will favor constructive metamorphosis, and believing as I do that the bromide of potassium is a brain bleacher, that it diminishes the blood supply to the brain, thereby withholding from the partially degenerated blood vessels that which is necessary for repair, I would not give it. Every tissue and organ in the body is but an aggregation of cells—any pathology not based upon diseased cell life is defective—and if there is low cell life the use of any medicine tending still farther in that direction savors largely of the doctrine of *similia similibus curantur*. I will not at present go as far as some pathologists do and assert that even hypertrophy is the result of impaired cell life.

I would give nux vomica, ergot damiana and phosphorus, and if death did not occur early, the iodide of potassium, for reasons that are obvious to you all. In chronic or passive apoplexy I would attach much importance to life free from excitement, mental and physical, no straining at stool and the judicious use

of iodide of pot. and ergot and a generous diet.

I have not discussed the cause of apoplexy except the degeneration of the walls of the vessels as the immediate antecedent in point of time and also of causation from a pathological standpoint. The real and often preventable cause antedates the attack many years. We admit the possibility of disease in any part of an organism that is unstable, of an inflammation with its products or degeneration of tissue from impaired nutrition which is purely idiopathic and is, therefore, not preventable.

In a large per cent. of cases the predisposing cause, *over-tension of the brain and nervous system* begins in our public schools under the instruction of some young and inexperienced teacher who knows nothing of the intensity or duration of the tension that minds of different ages or of different temperaments can sustain without doing violence to the organism.

This pernicious cramming begins too soon and is carried on too long. Immediately supervening upon the tension of school life comes the tension of professional studies followed by the cares, anxieties and responsibilities incident to the professions. If business or labor is to be the pursuit of life, it begins at once, or even before school life closes, so that with the masses there is over-tension, mental and physical, from the cradle to the *apoplexy, softening of the brain* or insanity. What the people need is less labor, mental and physical, and if political economy demands it, greater pay for their services; more sleep and more amusement and there will be less need for works written upon the subject of brain and nerve diseases. Man is the product of his environments. It is the environments that are at fault. Let us correct them.

## DISEASES OF THE NERVOUS SYSTEM.

### Cerebral Vacuolation.

At a recent meeting of the London Pathological Society (*British Medical Journal*), Dr. WHITE read a paper written conjointly by Dr. Savage and himself, on vacuolation of the cerebral substance. It was shown that there were nine causes for holes in the brain: 1. Small processes of sclerosed meninges, in cases of general paralysis, dipped into and excavated minute portions of cerebral tissue. 2. In the same disease the sclerosed neuroglia, by its contraction, might give rise to small cavities. 3. There might be multiple hydatids in the brain. These three conditions were very rare, the authors having no knowledge of the second, while the third was almost confined to animals suffering from staggers. Several references to continental authors were given, while the relation of the muslin appearance to the second of the above was pointed out. 4. The fourth cause was the dilatation of cerebral vessel, giving rise to the "*état criblé*." It was particularly emphasized that this was, in the majority of cases, of no pathological significance. 5. Shrinking of the cerebral convolutions, in some cases, gave rise to holes in the subjacent cerebral substance; a very good example of this condition was exhibited. 6. Miliary aneurisms, as Charcot had pointed out, might give rise to holes in the brain-substance; some very marked specimens showing this were exhibited. 7. In the condition known in Germany as *die Porencephalie*, a large gap existed in the brain-substance; this might communicate either with the exterior or the interior of the brain, or both. 8. The Gruyère cheese condition. This, it was pointed out, was quite different from the *état criblé*, for it was due to a dilatation of the peri-

vascular lymphatic space of His. Of the causes of this dilatation nothing was known; probably they were local, and the dilatation was saccular. The authors showed an example of this condition in which the whole of the brain, except the lower part of the medulla, was riddled with cavities exactly like those found in cheese, and microscopic specimens exhibited showed that these holes were produced by this perivascular dilatation. The shape and direction of the cavities also corresponded with that of the vessels. Very few examples of this condition had been carefully described; in England only one, by Lockhart Clarke, who referred it to the same cause. 9. The authors showed specimens from two remarkable cases, in which the kidneys, lungs, liver, heart and brain all contained holes; in the kidney, these cysts were due to the dilatation of either the tubules or Malpighian capsules; in the liver they were due to the vacuolation of the hepatic cells; in the lungs and brain it was impossible to come to any definite conclusion as to their origin, but in both these viscera the cavities contained a peculiar material, staining deeply with logwood; both the subjects were lunatics. Cases in which there were found only a few holes, such as patches of softening hemorrhage, were not considered to come within the scope of the paper. Dr. Savage said that, in the cases of the two lunatics last referred to, the changes were certainly not due to changes produced by preservative fluids after death, as the vacuolation was noticed at the necropsy. Both the patients were general paralytics, but in one the disease was chronic (three or four years), in the other acute (three or four months). He was convinced that the vacuolation occurred under various conditions—*Med. Record*.

#### Succus Conii in Chorea.

Mr. J. F. W. SIEK reports in the *Lancet* some cases of chorea relieved by succus conii. These cases seemed to show:

1. That the drug, to be of any service, must be given in large doses.
2. That its action must be sustained by frequent repetitions of the dose at short intervals. The uncertainty of the action of given specimens of succus conii, necessitates great care in its administration, and militates against its general adoption. But cases in which neither chloral nor morphia have any effect, may arise, and in which, as in the above, succus conii may prove efficacious.—*Med. and Surg. Reporter*.

#### A Symptom of Lesion of the Sympatheticus.

Dr. E. CLÉMENT (*Rev. de Méd.*) had the opportunity of observing two cases, in which one characteristic symptom existed which proved lesion of the sympathetic nerve. In the first case a carcinomatous growth had caused softening of the dorsal spinal cord at the seventh dorsal vertebra; the sympathetic was included in the new growth. When C. passed with a dull instrument over the skin, not only a redness appeared over the place touched but also a swelling similar to the one noted in urticaria. This could be induced all over the surface of the body.

In a second case the diagnosis was morbus maculæ Werthofii. Here the same symptom was noticed, with the difference that these phenomena appeared by themselves. C. believes that in both cases a lesion of the sympathetic nerve caused the symptom, which is the opinion of many observers.—*Med. and Surg. Reporter*.

### Angina Pectoris.

GUNSBURG has treated angina pectoris (*Revue Médicale*), when due to a neurosis of the cardiac nerves, by cold compresses placed over the chest. They produce at once a diminution in intensity of pain and force of the heart beats. They succeed best in young subjects. In older persons heat may be substituted for cold. In conjunction he would give opium and belladonna every four hours. He has never employed hypodermics of morphine over the precordial region, but thinks they might be of advantage. He recommends gymnastic exercise as of especial benefit.—*Weekly Med. Review*.

### Treatment of Gouty Pains and Neuralgia by the External Application of Nitrate of Silver.

DR. FROMMÜLLER (*Memorabilien*) rubs the solid stick over the moistened surface for about thirty seconds. When dry, the skin is covered with a compress of salicylated cotton, which is removed once or twice a day until the blister is healed. In order to be efficient the irritation should be sufficient to cause an exudation beneath the epidermis.—*Med. and Surg. Reporter*.

### Lumbago

May be quickly relieved (*Scientific American*) by binding a piece of oilskin cloth, such as is used to cover tables, over the loins outside of the flannel shirt. Profuse perspiration is produced, which rapidly relieves the pain.

### DISEASES OF THE URINARY ORGANS.

#### Filarial Hæmato-chyluria.

DR. S. MACKENZIE records the case of a soldier, a native of Madras, but born

of European parents, who, after arriving in England, found that his urine became increased in quantity, turbid, slimy, and by degrees quite milky. A little later he was seized with a sudden violent pain, extending from the left loin to the left testicle, and was admitted into the military hospital, and thence transferred to Dr. Mackenzie's care. The urine averaged one hundred and twenty ounces in daily quantity, its specific gravity was about 1.010, neutral or faintly alkaline, and contained always some albumen, but no sugar. The urea averaged .6 per cent. Ether readily removed the milky color. It deposited blood, triple phosphates, rarely oxalates, bacteria, and embryo filariæ sanguinis hominis. The blood at night contained numerous filariæ, the maximum being reached at midnight, but they were absent during the day. By inverting the order of his life, so that he slept by day and was up at night, this condition of things altered, too, and the maximum of filariæ in the blood was then at noon. After being under observation some time, patient got a chill, had a rigor, followed by signs of pneumonia at the left apex. This was followed by abscesses at the root of the neck and left shoulder-joint, which were opened. From the date of this illness the urine ceased to be milky, and the filariæ disappeared from the blood. The patient ultimately died, with empyema of right side of chest. The kidneys were slightly enlarged and in early stage of suppurative nephritis. The mucous membrane of the bladder was thickened, covered with mucus, and contained extravasations. The abdominal lymphatics were carefully dissected and found to be greatly dilated. The thoracic duct was dilated below and obliterated above. Lymphatics of the left kidney were especially dilated and contained

calculi. No trace of the parent worm could be discovered. No communication could be traced between the dilated lymphatics and the urinary passages.—*London Medical Record.*

#### Hygiene of Albuminuria.

SENATOR (*Berlin. Klin. Woch.*) especially emphasizes the following features of the hygienic treatment of albuminuria: 1. The question of the nourishment of patients with nephritis should include a consideration of the influence exercised upon the albuminuria both by the condition of the digestive process itself and by the character of the nourishment. 2. The rule may be accepted in general that with albuminuria the wants of the system should be supplied rather by frequent small quantities of food than by larger amounts at longer intervals. 3. Eggs should be forbidden; meat and cheese used sparingly, and of meats preferably veal or poultry; fish is to be recommended; fruit and vegetables are indicated, but the leguminous varieties less so; the use of fat is to be governed by the state of the digestion; spiced, smoked and salted viands are unsuitable; red wine may be used moderately; beer, spirits and the heavier wines are to be avoided; a milk diet is extremely useful, but, that it may be sufficiently prolonged, bread or some similar addition should be made. 4. Saline or alkaline-saline waters, warm or cold, according to the case, are found practically to act favorably, and this probably by effect upon the digestion and composition of the blood, as theoretically they should be a renal irritant; saline baths are useful through their congestive and stimulating effect upon the skin. 5. Muscular exertion should be very restricted. 6. An even body-temperature should be sought by clothing, by climate, by retirement to

bed if necessary. For clothing, flannel should be worn next the skin; for a climate, a warm and dry one should be selected, free from sudden changes, with a mean temperature from 60° F. to 70° F. 7. Psychical influences are of great importance in this condition. 8. With women during menstruation the amount of albumen excreted is always increased, and they should during that period be confined strictly to bed.—*Boston Medical and Surgical Journal.*

#### Presence of Phosphate of Magnesium in the Urine of Persons Suffering from Affections of the Stomach.

A man, æt. 49, suffering from a chronic affection of the stomach (dyspepsia, constipation, frequent vomiting), discharged urine which was free from albumen and a sediment, but was alkaline, and whose reaction was caused by a fixed alkali. Letting the urine stand for five days in a warm room had not made it ammoniacal as yet, but there now appeared a sediment of transparent crystals (four-sided prisms), which by their shape, as well as by their reaction to carbonate of ammonia (opaque and stripes, especially in the longitudinal direction), proved themselves to consist of phosphate of magnesium. Such a sediment formation out of an alkaline urine (whose reaction in this case was caused by frequent vomiting and the abstraction of acid from the system necessarily connected with it) seems to be very rare, and to happen then only, when, after letting the urine stand for a number of days, the decomposition of urea into carbonate of ammonia, and the formation, connected therewith, of phosphate of ammonia—magnesia—has not taken place. As the occurrence is so rare, and can be caused only under the circumstances mentioned, it may be

possible that the fact, by further investigations, may become an important one in the always difficult diagnosis of certain obscure diseases of the main organ of digestion.—*Deutsch Arch. of Klin. Med.—Med. and Surg. Reporter.*

#### Suppositories in Chronic Cystitis.

Against the attacks of pain, which supervene in chronic cystitis, the use of anodyne suppositories frequently gives greater relief than any form of internal treatment. The following prescriptions of Mallez and Mayet will prove useful:  $\mathcal{R}$  Morph. hydrochlorat., 1 to 2 centigrams; stramonii, pulv., 2 centigrams; ol. theobromæ, q. s. M. For one suppository.  $\mathcal{R}$  Hydrat. chloral, 3 grammes; ol. theobrom., q. s. M. For one suppository.—*Ibid.*

#### DISEASES OF RESPIRATORY ORGANS.

##### The Uses of Creosote.

From the *Analyst*, No. 80, vol. 7, we learn that *pure* creosote, *not carbolic acid*, proves beneficial to consumptives and sufferers from chronic catarrh; it is also markedly anti-asthmatic. The proper adult dose is from one-third to two-thirds of a grain two or three times daily. The maximum single dose is three-fourths of a grain. It is best given in pills made by melting two parts of yellow wax and one of creosote, to which any other ingredients desired may be added.—*Med. and Surg. Reporter.*

##### Aluminium in the Treatment of Phthisis.

Dr. JULIUS PICK, of Pribyslau, announces the successful use of aluminium in the treatment of pulmonary tuberculosis. Aluminium, he states (in the *Wiener Medicinische Wochenschrift*), is

one of the most active destroyers of the bacillus of tuberculosis, and assuming that this bacillus is the cause of the disease, the metal in question may be rationally given as a remedy against it. When so administered it kills the bacillus and takes away the specific character of the disease. If, however, serious organic changes have occurred, the drug will not remedy these; hence, in the later stages of phthisis, when much tissue has been destroyed, we can expect no good from Dr. Pick's treatment.

The method employed by the investigator in question is illustrated by the history of a young man, both of whose lungs revealed the changes of the first stage of phthisis. He was ordered the following:  $\mathcal{R}$ . Aluminii metall., 1.00 gramme; aluminæ hydr., calc. carb. depur.,  $\text{āā}$  5.00 gramme; gum tragac., q. s. M. Div. in pil. No. 60. Sig. one t. i. d., two hours after eating. The lime was added to assist in the calcification of the tubercle. He was also ordered to be rubbed all over twice daily with oil. After eight days the diarrhoea and night-sweats had ceased, the fever had left him, and his appetite returned. He was treated for nine weeks, at the end of which time he seemed to have nearly, if not entirely, recovered. The average dose of aluminium was about 0.10 gramme daily.

Dr. Pick reports the above case as a sample of what the metal will do. He does not say how many others he has treated. It is evident that he has not proved very much for his new remedy as yet.—*Med. Record.*

##### Hot Water as a Gargle.

Dr. RITZY has found hot water, systematically employed as a gargle, of great benefit in overcoming the sensation

of rawness incident to acute pharyngitis. He found that the use of hot water paleed the red and inflamed mucous membrane more or less permanently. And so far as unpleasant personal sensation went, it cured the pharyngitis. He also believes that this simple plan of treatment would prove beneficial in diphtheria, in patients old enough to gargle intelligently. In ordinary tonsillitis hot water, he thinks, would hardly fail to act well. The water should be used as hot as as can well be borne, and gargling should be practiced for several minutes at a time.—*The Medical Age*.

#### Auscultation.

Dr. D. DRUMMOND (*British Medical Jour.*), finds auscultation of the trachea by means of a stethoscope, with the chest-piece inserted into the mouth of the patient, useful in the diagnosis of tracheal compression, particularly when produced by aortic aneurism, in which case a systolic whiff is heard with each expiration. Auscultatory percussion practiced on this plan gives valuable indications in pulmonary disease. Thus in incipient phthisis a peculiar note is obtained, closely resembling "cracked-pot" resonance; in pleurisy, a very short, high-pitched note is produced, very different from the low-pitched, more prolonged, and much louder tone heard if pneumonic consolidation exists.—*Weekly Med. Record*.

#### Pharyngitis.

Two grains of the chloride of ammonium, combined with ten or fifteen minims of the tincture of cubebs, given every half hour, oftentimes controls acute pharyngitis and superficial inflammations of the other tissues about the throat. For inflammation of the throat

dependent upon a gouty diathesis, add to this mixture ten minims of the ammoniated tincture of guaiac, and administer every hour.—*Med. Brief*.

#### Phthisis, Bronchitis and Pneumonia.

A paper on phthisis, bronchitis and pneumonia was read at the meeting of the Epidemiological Society of London by Dr. G. B. LONGSTAFF (*London Lancet*), whose conclusions were: 1. That the mortality statistics of England and Wales did not give any evidence in favor of the view that phthisis is communicable, but they showed that the death-rate from phthisis was not influenced by the weather. 2. That while bronchitis and pneumonia were greatly influenced by meteorological conditions, it was difficult to explain by those conditions alone all the phenomena. 3. That common catarrh was a communicable disease, and that it was probable that very many cases of bronchitis and pneumonia might be looked upon as complications of that or some similar disease of mild character when uncomplicated. 4. That the different incidence of bronchitis and pneumonia on the two sexes pointed to some difference in the causation of the two diseases. 5. There would appear to be some common factor in the causation of phthisis and tubercular meningitis.—*Weekly Med. Review*.

#### DIGESTIVE TRACT.

##### Absorption by the Peritoneum.

MAFFUCCI's experiments (*Giornale Internaz. delle Scienze Med.*) were undertaken with the object of determining whether, besides the diaphragm, there are other absorptive points of the abdominal cavity, or whether it is an absorbing surface in all its extension. From

experiments on dogs he arrives at the following conclusions: 1. The diaphragm, great omentum, broad ligament, gastro-hepatic and gastro-splenic ligaments, the folds of Douglas, the mesorectum, and exceptionally the mesentery, are absorptive of corpuscular fluids. 2. Where absorption of these fluids takes place, there is a modification of structure in the peritoneum, in the epithelial lining, as well as in the subjacent tissue; in the diaphragm there are lymphatic lacunæ, in the rest of the peritoneum lymphatic follicles, which, from these experiments, receive their physiological importance, hitherto conjectured only. 3. Corpuscular fluids are taken up by the lumbar and aortic glands, those of the hilum of the liver and spleen, and of the curvature of the stomach. 4. These fluids, absorbed by the diaphragm, are poured as much into the more complex glands of the mediastinum, as into the system of follicles. 5. Comparing the abdominal cavity, and also the mediastinum, with the general anatomy of the lymphatic system, in the dog, the first as well as the second may be justly considered as a lymphatic gland with the respective follicles.—*N. Y. Med. Journal.*

#### Dysentery and Liver Abscess.

In a paper on the relation of hepatic abscess to dysentery, Sir J. FAYRER (*Lancet*) summarizes his opinions as follows: 1. The so-called abscesses which originate in local deaths of parenchyma (pyæmia, embolic deposits, or infarcts) are cavities varying in size from a mere speck to an orange, containing débris, sanies, puriform matter, leucocytes, and, finally, pus. They are seen in various stages of development, and are not necessarily confined to the liver, but occur in other viscera or regions of the body.

These are truly pyæmic. 2. There is a form of liver abscess co-existent with, and perhaps due to, dysentery, which is the result of direct absorption and transference of pus or septic matter from the bowel to the liver through the mesenteric veins. Such may be solitary, double or triple. This is also a very dangerous form of the disease, though not necessarily fatal, as it is feared must always be the case in the former variety. 3. Dysentery, malarial fever, and hepatitis may co-exist, or supervene on each other as effects of common climatic cause; it seems natural to ascribe the liver abscess in such cases to the dysentery, but it is probable that they are rather coincidences than consequences of each other, and that the cause which affects the glandular structures of the large intestine may determine the mischief in the liver in certain climates and localities; such are obviously very different from those previously mentioned. 4. The ordinary large and most frequently single tropical abscess is quite independent of dysentery, though it may co-exist with or follow it. Each or all of these forms may, in England, be the result of disease originally contracted in certain climates.

#### Mode of Reproduction of the Liver.

While conducting some experiments upon the spleen of a dog, Dr. TIZZONI accidentally wounded the liver at the edge of one of its lobes. Six months later he discovered a tumor at the exact point where the wound of the liver had been made. It had all the gross appearance of the liver substance. A portion was treated with bichromate of potassium and alcohol, and then numerous transverse and longitudinal sections were made. From a study of these the author arrived at the following conclu-

sions: 1. Under certain circumstances the liver may be produced at the point where it has been wounded; there is a new formation of hepatic cells and biliary ducts. 2. Unlike what occurs in the spleen, the great omentum adherent to the wound in the liver does not take part in the reproduction of the substance of the organ, but serves merely as the stroma in which the newly-formed tissue arises and is developed. 3. The new tissue arises from the pre-existing hepatic cells, which, by cellular multiplication, send out offshoots which penetrate into the epiploön like the prolongations of an epithelial tumor in the connective tissue of the skin; the hepatic cells present numerous nuclei, sometimes as many as twelve, which are deeply stained by carmine. 4. Some of these cellular prolongations have a light centre and assume the appearance of bile-ducts, while others are filled with protoplasm and nuclei, and resemble then the hepatic cellules. 5. The newly-formed hepatic cells, which resemble histologically the old ones, have that in common with the hepatic cells of the embryo that they remain for a long time separated by true lacunæ filled with blood. 6. The acinous disposition is wanting, but large blood-vessels, especially veins, and biliary ducts can be seen. The author concludes from this that the regeneration of the liver is in all points identical with the embryonic development as described by Remak and Kölliker.—*Journal de Médecine de Paris*.—*Med. Record*.

#### A New Use for Chloral Hydrate.

B. BONATTI recommends chloral hydrate in combination with senna as a rapid and safe drastic cathartic. He prescribes: *R. Infus. sennæ, fl. ʒ x.; chloralis hydratis, gr. xxiv.-l.; syrupi, fl ʒ j.* With this he obtained an action

where cotoin and jalap had failed.—*D. Med. Zeitung. Pharmaceutische Centralhalle. Ther. Gazette.*

#### The Clay-Colored Stools in Jaundice.

Professor GERHARDT states that the clay-colored stools in icterus contain a great number of needle-shaped crystals arranged in bundles. Sometimes the quantity of crystals is so great that the fecal mass seems to be in great part made up of them. Their shape is suggestive of tyrosin, but mixed with the needle-shaped crystals here and there are little spheres resembling leucin. The fæces, when stirred up with water, settle in four layers. The upper layer is thin, milk-white, and consists almost wholly of fat drops. The three other layers (flaky, watery and sedimentitious) contain the crystals in nearly equal proportion. Some of the clinical tests also show the presence of tyrosin. Since only colorless stools contain these crystals, there can be no doubt that their presence is in some way connected with icterus. But whether it is due to the continued action of the gastric juice in the intestines, or to the action or non-action of the pancreatic juice without the addition of bile, or whether it is a result of the decomposition of the ingesta in the intestine, are questions which the author leaves unanswered. He also suggests, without deciding the question, that this quantity of tyrosin in the intestine may be accountable for the appearance of the same substance in the urine. The white or whitish gray color of the stools proceeds from the presence of either fat or these tyrosin crystals.—*Deutsche Medicinal-Zeitung.*

**CONSTITUTIONAL DISEASES.**

**Practical Points from Philadelphia Clinics.**

Dr. CARL SEILER removes polypi from the nasal cavities with the snare, as this causes less bleeding than the polyp forceps, and touches them with galvano-cautery. This prevents the return of the growth, which nothing else will, the doctor having tried iodine, chromic acid, etc. This procedure certainly merits further trial.

Dr. WHARTON recommends that superficially situated nævi be cauterized with the strong nitric acid, applied with a glass rod. The resulting slough is followed by a white cicatrix. More extensive nævi call for other treatment.

For catarrhal, or herpetic, or diphtheritic tonsilitis Prof. PEPPER recommends constitutionally absolute rest, large doses of quinine, drop doses of tincture of aconite, and liquid diet, and locally the application of the muriated tincture of iron.

Prof. TYSON often prescribes a mustard plaster prepared with molasses instead of water. For prolonged and mild counter-irritation this acts excellently, as patients often have the plaster on their backs for hours while fulfilling their daily duties. Dr. Tyson also has great faith in jaborandi and its active principle, pilocarpin, in the treatment of uræmia. He considers it *the* remedy for such cases. In Bright's disease and in diabetes the doctor prescribes an exclusive milk diet. He gives only skimmed milk.

Dr. STRAWBRIDGE poultices the external ear in the following ingenious manner: He lays the patient's head on the table and fills the external ear with as hot water as can be borne. Over the ear are applied towels soaked in very hot water, the surplus water being

drained off by squeezing the soaked towels between dry ones.

For eczematous sores in children and old people Dr. DUHRING recommends an ointment of five grains of iodide of lead to the drachm of vaseline.

Dr. LOUIS A. DUHRING recommends for acne, sulphur in some form; preferably the sulphide of calcium internally, and locally the following prescription at bedtime:  $\mathcal{R}$ . Sulphuret. potash, 3 ss; sulphate zinc, 3 ss; glycerine, 3 j; alcohol, fl 3 j; water, fl 3 j. M.

Dr. ELLERSLIE WALLACE describes nux vomica as the great invigorator of the sexual organs. He gives the one-half to one grain dose of the extract of nux vomica three times a day after meals.

Dr. JOHN ASHHURST, Jr., says it is the surgeon's rule for ligation of an artery to cut down over the pulsation of the artery where he feels it. Of course the surgeon should know the anatomy of the parts, as well as the lines for cutting as laid down in the books.

Prof. DE COSTA says do not aspirate pleuritic effusions as long as no urgent symptoms, such as failure of the heart and symptoms of blood-poisoning, demand it, for the liquid will generally reaccumulate, and the second time it will be purulent. Give iodide of potash and other remedies to promote absorption and to make the kidneys act. For the latter the infusion of juniper and jaborandi internally, and dry cupping over the region of the kidney will be often of benefit.

Prof. TYSON divides the treatment of acute rheumatism into three kinds to suit different types of cases. Rheumatism occurring in persons of nervous rheumatic temperament who lead a sedentary life, but are otherwise well fed and clothed, should be treated by salicylic acid or the salicylate of sodium;

twenty grains of the latter every four hours for the first twenty-four or forty-eight hours. Continue the medicine after convalescence is established for some time—about as many days as the disease itself lasted. Rheumatism occurring in obese persons who are free livers and who use malt liquors will be best treated by the alkaline treatment. One and a half drachms of bicarbonate of soda in lemon juice every four hours for four days, afterward twenty grains three times a day combined with iron and quinine. Rheumatism occurring in anæmic persons who have been underfed and overworked should be treated with the tincture of iodine. When the types shade into each other give the salicylic acid with the other treatment. The diet should consist of skimmed milk, chicken or mutton soup, beef broth or other liquid diet. Anodynes and the old "six-weeks-abed" treatment have gone out of date.

Dr. WM. GOODELL, the world-famed gynecologist of the university, recommends for pruritus vulvæ: *R.* Carbolic acid, 3 j; morphine sulphate, gr. x; boracic acid, 3 ij; vaseline, 3 ij. M. And also the patting of the parts with a sponge soaked in boiling-hot water. This is also a most excellent application for that rawness so often found between the thighs of the newly born.—*Med. Herald.*

#### Pulse and Temperature in Typhoid Fever.

M. MALHERBE, in a recent *Thèse de Paris*, remarks that the frequency of the pulse in this disease is not always in proportion with the elevation of temperature. The temperature often becomes very high without a corresponding change in the pulse, and inversely, the pulse may become very much accelerated without any extra elevation of temperature. In any febrile affection where,

with a high temperature, the pulse remains almost normal in frequency, typhoid fever should be thought of. The prognosis is not generally bad when the pulse remains at 80 or 90 beats per minute, even when the temperature amounts to 104° or 105°. But when the pulse is very frequent in conjunction with this high temperature, then the prognosis is grave. When, on the other hand, the temperature suddenly falls, while the pulse remains very frequent, the prognosis is equally grave.—*Med. & Surg. Reporter.*

#### Fatal Œdema of the Glottis in Typhoid Fever.

Dr. MERKLEIN reports a case of tracheotomy for œdema of the glottis in the course of typhoid fever in a woman, 24 years of age. Previous to this complication the nares had been plugged on account of epistaxis. Probably mouth-breathing may have induced this condition of the larynx. Death followed the operation, due to hemorrhage from the air-passages.—*La France Médicale.*—*Med. Med. Jour.*

#### Treatment of Typhoid Fever.

Dr. I. P. KLINGENSMITH (*Med. Record*):

When I find the patient to have typhoid fever, or when his symptoms indicate that the disease is about to develop, I order him to bed and put him on a liquid diet, consisting of milk, beef-tea, or animal broths. I then order the following mixture, as recommended by Bartholow: *R.* Tr. iodinii, 3 ij.; acidi carbolici, 3 j. M. Of this mixture I direct three drops to be given in a wineglassful of iced or cold water, three times daily, after meals, and which is continued until convalescence is well established. As a rule, this medicine is

well borne by the stomach, and occasions no disgust on the part of the patient. Partly for its favorable influence upon the skin, for the sake of cleanliness, and also the slight influence upon the temperature, the patient is sponged twice daily with equal parts of alcohol and water, or in some cases, where more grateful to him, with tepid water.

When I find the evening temperature to reach  $103^{\circ}$  F., quinine in large doses is administered, upon a falling temperature. I usually direct at least thirty grains to be given, one-half the quantity at 5 A. M., and remainder, if deemed necessary, at 5.30 or 6 A. M.

This quantity, as a rule, will lower the temperature from  $2.5^{\circ}$  to  $3.5^{\circ}$  for the next forty-eight hours, after which it may be found necessary to repeat the medicine. In a few cases where the temperature has reached  $106^{\circ}$  F. I have given quinine amounting to fifty and even sixty grains, succeeding most happily in reducing the temperature without any sustenance of injury to the patient.

For the relief of the headache in the early stage of the disease I find the following to answer the indications: *R.* Quiniæ sulph., gr. ij.; *ex.* belladon. gr.  $\frac{1}{4}$ . *M.* et *ft.* in pilula. *Sig.*—One pill every three or four hours.

Alcohol is not often indicated until after the close of the third week, unless, by reason of the habits of certain patients, it may be necessary throughout the attack. In the event of heart-failure it must be administered according to the exigencies of the particular case. A majority of patients do well without taking it at all. Should the diarrhœa become excessive I direct a pill as follows: *R.* Argenti nitratis, gr.  $\frac{1}{2}$ ; pulv. opii, gr. j. *M.* To be given every four hours until brought under proper con-

trol. On the other hand, should obstinate constipation intervene, I never hesitate to give a dose of calomel, unless there are reasons to suspect serious intestinal lesions, in which event the bowels may be emptied by enemata.

To prevent hypostatic congestion of the lungs, the patient is turned upon his side from time to time. As an invariable rule from the recognition of the disease, the patient must maintain the horizontal position until convalescence is well established.

During the sickness the patient should have a competent nurse, whose duty it is to attend to the punctual administration of the medicines and diet. A liquid diet, consisting of milk, beef-tea, or other animal broths, must be given every two or three hours. Perfect quiet must be maintained in the sick-room, all visitors being positively excluded. The room should be kept darkened, all pictures and paintings removed from the walls, and the medicines kept out of sight of the patient. Perfect ventilation must be secured. To avoid establishing a focus of contagion, the dejections must be systematically disinfected immediately after being voided.

The total number of cases treated by this plan is fifty-two, with a recovery of all. Of the cases, twenty-eight were severe, the temperature in three reaching  $106^{\circ}$  F., and in the other twenty-five  $103.5^{\circ}$  to  $104^{\circ}$ . In three of the cases a mild attack of rheumatism set in during convalescence. In two cases a severe relapse from indiscretion in diet prolonged the disease. The average duration of the severe cases was about thirty days, and of the milder about twenty-six days.

### Corrosive Sublimate in the Treatment of Diphtheria.

KAULICH (*Bull. de la Soc. de Méd. de Gand*) has used in a number of cases corrosive sublimate, both locally and internally, in the treatment of diphtheria. He treats the exudation in the nose, the mouth and the throat by the applications of a solution of 1 in 2000. Among cases of infants that have had tracheotomy performed, the trachea is painted with the same solution four times daily, or even every two hours. Inhalations were likewise ordered of .005 in 1000 fifteen minutes at a time, repeated every hour or less frequently, according to the case. Internally, he gives to children one or two centigrammes, (gr.  $\frac{1}{8}$ — $\frac{1}{4}$ ) daily in albumenized water containing a little cognac and sugar. Warm applications to the outside of the throat are likewise made.—*Bull. Gén. de Thérapeutique*.—*Med. Times*.

### Diphtheria and Croup.

Dr. R. WOOD (in *Midland Medical Miscellany*) translates the following from *Centralblatt für Med. Wissenschaften*: Dr. Kenock draws a strongly marked distinction between diphtheria and croup. He says (a) In diphtheria there is very little fever, whilst in croup the fever runs high. (b) In diphtheria both sides of the throat and posterior wall of the pharynx are affected, and even the uvula becomes covered with membranes sometimes; whilst in croup only one side is affected at first, and the uvula is comparatively free. (c) In diphtheria the mucous membrane of the nose seldom escapes, whilst in croup it always does.

### Thirty Years' Personal Experience in Diphtheria.

Dr. BEDFORD BROWN (Medical Society of Virginia) thought, from his ob-

servation, that two of the gravest symptoms in this disease are the peculiar erratic decline of the heart's action and the almost correspondingly rapid decline in the number of red corpuscles in the blood. His experience has taught him to believe thoroughly in the non-identity of membranous croup and diphtheria. It seemed to him very often that the cases where fever remained when the local symptoms began to abate succeeded the best. He recalled the time when diphtheria was considered a malignant type of a local disease. One of the very great favorites in local treatment then was a mixture of myrrh, creasote, and turpentine. He pointed out the different modes of using mercury. Formerly emetics were given, and then mercury in large sedative doses; in later times we give the latter in small, frequent, alterative doses. Quinine has held favor for use in this disease longer than any other drug, certainly for over a quarter of a century. He thinks that the paralytic effect of the diphtheritic poison on nervous systems can best be retarded by alcohol. He never saw a serious case recover where alcohol was not used. His experience has taught him that if belladonna, ergot, or digitalis cannot stay the paralyzing effect of the poison on the heart through the sympathetic system nothing else will. Such powerful agents as bromine and carbolic acid should be used locally with great caution. Dr. Brown always pays the greatest attention to the digestive organs during an attack of diphtheria, as in every serious case such organs are more or less in a condition of paralysis, and it often becomes a vital question as to how the patient shall procure enough strength from food to support the powers of life. He sustains the patient by means of diffusible stimulants, gives

them plenty of fresh air and digestible food, and believes in the great importance of keeping the nose and throat as clean as possible. For this latter purpose he uses with an atomizer, listerine, 1 oz.; aq., 4 oz.; Labarraque's sol.,  $\frac{1}{2}$  oz.; carbolic acid, 6 drops. Internally, tinct. ferri chlor., 2 dr.; chlor. pot. 1 dr.; tinct. nuc. vom., 20 drops; tinct. digitalis,  $\frac{1}{2}$  dr.; aq.,  $2\frac{1}{2}$  oz.; one teaspoonful every two hours.—*Med. Record.*

**Pinus Canadensis in Diphtheria.**

Dr. D. M. COOL, of Wamly, Iowa, sends a suggestive letter describing the results of seven years' experience with diphtheria while practising in Chicago. During this time he saw several hundred cases of all grades of severity. Before adopting the treatment which he now recommends, Dr. Cool had used sulphurous acid, chlorate of potash, iron, quinine, alcohol, etc., with fair success. He writes: "There came a time when my per cent. of deaths became much too large to be satisfactory. I was called quite early in the morning to see a child of Mrs. C —, three years of age. Two doctors had just left it, saying it could not live until night. While thinking over in my mind what I should do in the case, a thought struck me to try extract pinus canadensis fluid. Acting upon this thought, I wrote for Keneday's extract, to be applied to the throat by means of a soft swab once an hour. Internally, I gave Labarraque's solution chlorinated soda, five drops once in two hours. With this I gave milk, quinine and brandy. I called in the afternoon and was greatly surprised to find the patient better. From that time to this, in a large practice, I have used the following:  $\mathcal{R}$  Ex. pinus can., fl.  $\mathfrak{z}$ j.; carbolic acid (95 per cent.), gtts. x. M. Sig.—Apply (by means of a soft swab or camel's-hair brush) to the

throat once an hour. Also, internally, Labarraque's sol. chl. soda,  $\mathfrak{z}$ ij.; give, according to age, three to ten drops in water once in two hours. This, with the usual support, has been my treatment, with only the loss of four cases." A history of these cases is given, showing that in nearly every case the remedy could not be satisfactorily applied. Dr. Cool concludes: "I am not a believer in specifics, but this comes as near to one in my hands as well as in the hands of the physician whom I have given it to, as quinine is to a well-marked intermittent. In order to make it successful it must be applied frequently and thoroughly to the patient's throat, at least once an hour during the day, and once in two during the night. So far as I know, I am the first to use it in diphtheria. I had used it in leucorrhœa with fair success. The solution of chlorinated soda is useful through the chlorine it contains. In addition to this I apply salt to the throat externally."

**Perchloride of Iron in Diphtheria.**

M. E. DINAUD (*Union Médicale*) calls attention to the value of perchloride of iron in diphtheria, in which disease it should be used both internally and locally. He urges its use internally for the purpose of preventing the diphtheritic poison from modifying the composition of the blood. M. Regnard, when hospital interne under M. Jules Simon, performed the following experiment: Taking two specimens of blood, one from a patient who had died of diphtheria, and the other from a patient who had succumbed to some other disease, he caused a current of oxygen to pass through each, separately. The blood from the non-diphtheritic subject quickly regained a bright red color, while that from the case of diphtheria remained of

a dark color. He was thus led to believe that diphtheritic poison deprived the blood of its property of absorbing oxygen, probably by destroying the hæmoglobin of the red corpuscles. And the efficacy of the perchloride of iron as a remedial agent in diphtheria he supposes to be due to the material it furnishes for restoring their hæmoglobin to the red corpuscles. The perchloride of iron may be given in a liquid form, two to six grammes being a suitable amount for a period of twenty-four hours. In some cases the dry salt is preferable. Dragées are now made, each representing four drops of the liquid perchloride. These may be given, one every two hours at first, and afterward one every hour. Thirty of the dragées are equivalent to six grammes of the liquid. As has been mentioned, this treatment should be combined with the local application of the iron to the diphtheritic patches.—*N. Y. Med. Journal*.

#### The Influence of Calomel on Digestion.

DR. VASSILIEFF (*Zeitschrift für Physiolog. Chemie*) has found, from experiment, that the presence of calomel, at least up to the amount of five grammes, in the alimentary canal, does not interfere with the gastric juice, nor affect the triple influence of the pancreatic fluid on albumen, fat, and starch. On mixing the latter fluid with fibrin and calomel, the formation of certain products, indol, etc., always appearing as a result of prolonged digestion under normal circumstances, is prevented. The gases generated in the process of pancreatic digestion contain none of the usual products of fermentation and decomposition when calomel is present; sulphuretted hydrogen and pure hydrogen are absent; carbonic acid is diminished to from two to ten per cent., whilst under

natural circumstances from fourteen to fifty-four per cent. is found in the gases evolved by the action of the pancreatic fluid. In fact, calomel prevents all other changes in nutritious substances save those produced entirely by the digestive secretions, decomposition and retrogressive processes in albumens being entirely checked. Calomel also prevents butyric acid fermentation, as Vassilieff found by experiments on cheese. The action of calomel readily explains the cause of the green color of fæces passed by patients to whom that drug has been administered. Hoppe-Seyler rightly attributed this coloration to the presence of unaltered bile. Now, under normal conditions, bilirubin and biliverdin are changed, by a process of decomposition, into hydrobilirubin, and thus become no longer recognizable in the excretion; but this process is arrested by calomel, and the coloring agents, unaltered, give the fæces their peculiar bright-green hue.—*British Med. Journal*.

#### Common Sanitary Defects in Dwellings.

MR. CHARLES F. WINGATE, in a series of papers on sanitary topics in the *Christian Union*, gives a concise list of the most common sanitary defects in dwelling-houses, and suggests that they should be kept in mind in the choice of a residence. The statement is also valuable as suggesting evils to be guarded against in household management, and indirectly impresses many important sanitary lessons. We commend it to the careful attention of all our readers:

Damp cellars, a prime source of rheumatism, consumption, diphtheria, and other diseases.

Broken drains under cellar floors, leaking foul gases to be borne upward into the living rooms of the houses.

Cellar drains connecting directly with

the sewer or cess-pool, without traps, or with traps whose water seal has evaporated.

Cess-pools under houses, forming reservoirs of foul gases which can have no other outlet but into the dwellings.

Defective cold-air boxes to furnaces, full of open joints and ending at yard areas, and conveying air saturated with soil moisture and laden with street sweepings, ashes, coal dust, and other offensive material, up through the furnace register, to be breathed over and over again by the inmates.

Foul servants' water closets in cellars, contributing their impurities to the furnace and household supply.

Refrigerator waste pipes running direct to the sewer and poisoning the food, especially the milk.

Old lead soil pipes, corroded by gases or gnawed by rats, so as to be in a dangerous state.

Broken tile or brick drains under the cellar floor, saturating the ground with filth, and evolving foul gases.

Cast-iron soil pipes full of sand holes, which are neither gas nor water tight, and with joints made of putty or cement.

Basins and other fixtures without traps of any kind, or with traps of unsuitable shape or size, which readily siphon by their own discharge or that of some other adjacent fixture.

Soil pipes without ventilation, which are breeding-places for sewer gas, which, from the absence of any trap on the main drain, readily enter from the street sewer.

Water supply tanks or cisterns for drinking water, with overflow pipes connecting with the sewer or with drains, and thus polluting their contents.

Pan water closets, outwardly clean to the eye, but foul and filthy within, creating offensive odors which commonly have a direct vent through the waste

pipes of adjoining baths and basins, while from shortness of the water supply they have insufficient flushing.

No householder has any assurance that his plumbing is properly executed, and that his family are free from the risk of sewer-gas poisoning, without an examination by a competent person. There need not be any leaks in the house; it may be free from offensive odors; and the occupants may not suffer sickness in years; yet examination will usually show numerous defects which no prudent man would wish to leave uncorrected.—*Popular Science News*.

## DISEASES OF THE NERVOUS SYSTEM.

### Cervical Pachymeningitis.

CHARCOT (*Le Progrès Méd.*) describes a case of paralysis due to cervical pachymeningitis. He points out that such cases pass through three stages: 1, the neuralgic period, characterized by severe pains and sense of constriction in the chest, a stage which lasts four, five, or six months; 2, the paralytic period in which paralysis occurs, accompanied by muscular atrophy; and 3, the spasmodic period, in which the lower limbs are affected by a spasmodic period paraplegia, the result of a transverse myelitis with descending degeneration of the lateral columns. The pathology of this affection is an inflammatory thickening of the dura mater, which may involve to some extent the nerves passing through it and the adjacent end, but in the main the symptoms are due to the compression of the inflamed membrane. Such cases occur independently of any diathesis or specific cause, often as the result of living in a damp place. Ultimately recovery may take place. In the case quoted this occurred partly spontaneously, partly as the result of

treatment which chiefly consisted of the actual cautery over the seat of the disease. Afterward there remained great contraction of the hamstring muscles, but these were divided subcutaneously, and by electricity and friction the patient recovered so far that he could walk about the hospital and go the distance of a mile without much fatigue.

#### **The Nitrous Compounds in Angina Pectoris.**

Dr. HAY has instituted a series of experimental observations touching the value of nitric, nitrous, and nitro-compounds in angina pectoris (*The Practitioner*). He concludes therefrom that nitrous acid in any combination, whether as an ether or a metallic salt, is useful in the treatment of angina pectoris; and that, in the case of the nitrite of amyl, the action of the acid is aided by that of the base. On the other hand, all compounds of nitric acid, whether ethereal or metallic, are without effect, unless it so happen that the constitution of the nitrate is such that it decomposes in the body with the liberation of nitrous acid. Further, nitro-substitution compounds have likewise no remedial effect. So far as at present known, the nitrogen-containing remedies for angina pectoris may be divided into two classes, the one consisting of combinations of nitrous acid with metallic oxides or alcoholic radicals, the other comprising a peculiar class of nitric ethers, obtained from the higher alcohols, whose decomposition within the body results in the production of nitrous acid. In both classes the action of the compound is ultimately dependent on nitrous acid present. Typical examples of the first class are nitrite of sodium and nitrite of ethyl, and, of the second class, nitro-glycerine. To these classes might be added another containing such substances as compounds of amyl, whose

action is similar to that of nitrites. But, limited as this group at present is to compounds of amyl, it is not one to be chosen in the treatment of angina pectoris. The dose required is large, and the action is not rapidly produced, and disagreeable after-effects are apt to occur; and altogether I am very doubtful of its always acting so well as it did in the case of my patient.—*Ibid.*

#### **Angina Pectoris Successfully Treated with Nitro-Glycerine.**

Dr. JACOB FRANK, of Buffalo, N. Y., relates the history of a married woman, aged thirty-one, mother of three healthy children, who had for six years suffered intensely from attacks of angina pectoris. Dr. Frank does not say whether there was any organic heart trouble. She was treated with morphine and various other remedies, but without success. Dr. Frank at first applied the faradic current over the pneumogastric, and got relief. During the next attack, however, this failed. The patient was then put upon nitro-glycerine, ℥ j. of the one per cent. solution gradually increased to ℥ vj., t. i. d.; then decreased. The patient has had no further attack. Dr. Frank writes: "During the course of this treatment a rather curious phenomenon occurred. After she had been taking this nitro-glycerine for about six weeks, aphthæ broke out on the tongue, mouth, and fauces. The medicine was stopped, and these ulcers treated with borax, etc., after which the treatment was again resumed." Dr. Frank gives the usual explanation of the curative action of the drug.—*Ibid.*

#### **Bathers' Cramp.**

Some recent bathing fatalities have again drawn attention to the important subject of bathers' cramp. If the nature

and causes of this dangerous affection were more generally known, it is probable that many deaths from drowning in the bathing season might be prevented. Cramp is a painful and tonic muscular spasm. It may occur in any part of the body, but it is especially apt to occur in the lower extremities, and, in its milder forms, it is limited to a single muscle. Pain is severe, and the contracted muscles are hard and exquisitely tender. In a few minutes the pains and spasms cease, leaving a local sensation of fatigue and soreness. When cramp affects only one extremity, no swimmer or bather, endowed with average presence of mind, need drown; but when cramp seizes the whole of the voluntary muscular system, as it probably does in the worst cases, nothing, in the absence of prompt and efficient extraneous assistance, can save the individual from drowning. Although the intimate nature of muscular cramps, and the precise mode in which they are established, are still unknown, experience has furnished us with sufficient data on the subject to enable us to recognize the chief conditions of their causation. These conditions are: a peculiar individual susceptibility or idiosyncrasy; the shock of cold applied to the general surface of the body; prolonged muscular exertion; and forcible and sudden muscular exertion, especially in the direction of the extension of the extremities. There can be no doubt about a liability to muscular cramp being an individual peculiarity. The disorder is especially apt to arise in persons of irritable temperament. While cramp has been met with in all ages, sexes, temperaments and climates, it has been observed that it occurs far more frequently in warm climates than in cold, and chiefly in the hottest of warm climates, and that persons of middle age suffer most from the affection, and men

more so than women, and the robust and vigorous more so than the weakly. Neither can there be any doubt that the shock of cold applied to the surface of the body, especially when the body is unduly heated, is the commonest determining cause of the worst and most extensive forms of bathers' cramp. On this fact is founded the common prejudice against bathing when the body is much heated. Many fatal cases have illustrated this point. Only a short time ago a robust soldier, who was an expert swimmer, rowed in a boat, upon a sultry evening, to a deep pool; here, with his body glowing from muscular exertion, he plunged into the water with the intention of taking a refreshing bath, when he was immediately seized with general muscular cramp, so that the poor fellow was at once drowned. That mere prolongation of muscular exertion, as in continued swimming, and forcible and sudden muscular exertion, particularly in the extension of the extremities, as in swimming with very vigorous and rapid strokes, are, respectively, efficient and frequent determining causes of cramp, familiar experiences to every swimmer. These muscular conditions, however, usually give rise only to the slighter and more localized forms of cramp. Serious cramp is a peril which menaces most persons with highly developed muscles. Its most powerful and most avoidable cause is the sudden immersion of the body, when its surface is highly heated, in water of a relatively low temperature. —*British Med. Journal.*

#### The Early Symptoms of General Paralysis of the Insane.

Dr. W. B. GOLDSMITH contributes an article on this subject to the *Archives of Medicine*, which concludes as follows:

1. That the striking and characteristic group of symptoms ascribed to the

disease by Calmeil in 1826, and having greatest prominence in most text-books since, is to be found only exceptionally in the cases of to-day at the time when the diagnosis is most important.

2. That physical and mental symptoms usually appear nearly synchronously, so that the physician has the presence or history of both to aid him when called upon for a diagnosis, and it is probable that most of those who report cases of general paralysis without mental impairment are not sufficiently expert to recognize a moderate degree of dementia.

3. That their observations agree with those of most writers in making defective articulation the most frequent and characteristic early motor symptom.

4. That changes in the pupils and disorders of gait are less frequent and have less value in diagnosis than is usually ascribed to them, and that given pupillary changes are no more frequent in one stage of the disease than in another.

5. That the patellar-tendon reflex is found markedly supra-normal in nearly twenty-five per cent. of general paralytics, and that the presence of this symptom is of strong corroborative value in diagnosis, though its absence has none, and that no peculiar condition of the patellar-tendon reflex can be associated with any given stage of the disease.

6. That hallucination or impaired function of the special senses is very rare as an early symptom; hallucination (auditory) having been noticed first in but one case, and impaired vision but once in a syphilitic case. The diminution in the sense of smell, which Voisin thinks very frequent in the early stages, was not noticed in any of my cases, though it may have been present and escaped attention in some, as slight failure is difficult to recognize.

7. That it is of great importance in the case of a patient showing mental symptoms to inquire carefully for a history of convulsions or loss of consciousness, as these were the first motor symptoms in twenty of my cases.

8. That among mental symptoms the marked exhilaration, with delusions of wealth and greatness, which is usually considered the characteristic mental symptom, is present early in less than one-fourth of the cases, and that simple failure of mental capacity and activity, and mental depression are the more frequent first mental changes.—*Med. and Surg. Reporter.*

#### The Treatment of Epilepsy.

In the course of an interesting lecture on epilepsy, translated from the French of Prof. B. BALL, by Dr. E. P. Hurd, and published in the *North Carolina Medical Journal*, the author deprecates the prolonged use of the bromides, which, while giving excellent results from the point of view of the convulsive attacks, may, in the long run, bring about a sensible impairment of the mental faculties. He prefers the mixed treatment, associating oxide of zinc and belladonna with the alkaline bromides.—*Ibid.*

#### The Therapeutics of Epilepsy.

Two cases of marked improvement of epilepsy after the administration of atropine are reported by Dr. Max WEISS, who declares that this agent is free from the disagreeable effects of the bromine preparations, and is efficient, in small doses, in lessening the force of the paroxysms and increasing the interval between the attacks. It is useful in all forms of epilepsy. After prolonged administration a decided tolerance is established, so that the dose may be materially increased without causing toxic symptoms.—*Centralblatt für die Ges. Therapie.*—*Md. Med. Jour.*

## DISEASES OF CIRCULATORY ORGANS.

### Physiological Action of Adonis Vernalis.

From a careful physiological and clinical study of the effects of Adonis vernalis, Dr. BUBNOFF arrives at these conclusions: 1. The active principle of Adonis vernalis excites the inhibitory nerves of the heart at the central end. 2. Its further action is to paralyze the peripheric end of the vagus. 3. It likewise excites the accelerating system of the heart, sometimes directly (through the blood-pressure), sometimes indirectly. 4. Up to the moment at which paralysis of the vagus occurs, the two systems of the cardiac innervation interfere. 5. At the termination of the toxic effect, paralysis of the motor nervous apparatus of the heart apparently occurs. 6. After death there is either complete loss of excitability of the cardiac muscle or it is very much weakened.

In man, this agent caused more gastro-intestinal disorder (vomiting and diarrhoea) than digitalis ordinarily does, and in certain individuals the effect upon the central termination of the vagus was more marked than from digitalis; and in one series of cases with disordered compensation of the blood-circulation, after digitalis had failed, the Adonis was given with decidedly good results.—*Deutsches Archiv für Klin. Med.—Mory. Med. Jour.*

### The Variation and Disappearance of Cardiac Murmurs.

Dr. E. HYLEA GREVES writes in the *Liverpool Medico-Chirurgical Journal* concerning the variations and changes so often observed in certain cardiac murmurs, dependent on definite organic lesions. He relates the histories of several cases, from a study of which he draws the following conclusions: 1. Al-

though murmurs are among the most constant of the physical signs of heart disease, still their presence does not necessarily indicate the existence of incurable lesions, nor their absence that such lesions are not present. In forming a correct diagnosis and prognosis of any case, therefore, too much reliance must not be placed upon the presence or absence of murmurs, but other symptoms must receive careful consideration, for often on them alone is it possible to form a correct diagnosis. 2. The pre-systolic murmur of mitral stenosis, the most typical of all murmurs, occasionally disappears, the lesion still remaining. Mitral regurgitant murmurs, when due to simple relaxation of the heart's muscle, and dilatation of its cavities and orifices, as in chlorosis and general febrile conditions, in most cases completely disappear under appropriate treatment. 3. Tricuspid regurgitation is occasionally a temporary condition, due to bronchitis, etc., and when the cause is removed this condition is recovered from, as is indicated by the disappearance of the murmurs. 4. Aortic systolic murmurs, due to a permanent lesion at the aortic orifice, may undergo changes in their intensity, but never completely disappear. 5. Aortic diastolic murmurs in certain extremely rare cases have been known to disappear. In these cases a systolic aortic bruit is always present and remains persistent, thus indicating the existence of the lesion. 6. Pulmonary systolic murmurs are persistent when due to an organic lesion; but if non-organic, may disappear temporarily or permanently.—*Med. Record.*

## DISEASES OF RESPIRATORY ORGANS.

### An Easy Method of Posterior Rhinoscopy.

The importance of visual inspection of the naso-pharynx and posterior nares

in all local diseases cannot be questioned. Ordinarily such examinations are attended with various difficulties. Dr. WALSHAM (*Lancet*) describes a simple method of overcoming these difficulties, admitting, however, that a somewhat similar procedure has for years been practised by some American specialists: A piece of soft red rubber tubing, about one-eighth of an inch in diameter, is introduced into one nostril, and pushed very gently along the floor of the nose till it presents just below the soft palate. It is then gently seized with a forceps, drawn out through the mouth, and loosely tied across the upper lip to the end protruding from the nose, the elastic tube being stretched just sufficiently to loop upward and forward the soft palate, and draw it well away from the posterior wall of the pharynx. The looping of the palate on one side is often sufficient; but a better view is obtained by passing a tube through the other nostril and looping up the soft palate of that side in the same way. The posterior nares and naso-pharynx can now be examined with the ordinary laryngoscopic mirror with the greatest facility. One hand only is required to hold and direct the mirror (the stem answering the purpose of a tongue-depressor), the other hand is consequently free to perform any manipulation or operation that may be required. The tubes serve as a good guide, as they can be followed in the mirror winding round the upper surface of the palate, and so into the respective choanæ. The introduction of the tube causes hardly any discomfort or annoyance to the patient. Care, however, should be taken in passing the tube to let it only just present below the soft palate, as otherwise, if it is pushed further, it may impinge upon the lower pharynx, and is then apt to produce a

tickling sensation and desire to vomit. When the examination is finished, it is better to withdraw the tube through the mouth rather than through the nose, and when the nasal end is just about to drop into the pharynx to give it a sharp whisk forward. If it is withdrawn through the nose, the mouth end trails along the tongue, causing a tickling of its posterior part. In place of the red rubber tubes, the American surgeons preferred to use flat tapes or narrow bandages for tying up the palate. These have necessitated the use of various instruments for passing them, such as the Eustachian catheter, Bellocq's sound, etc. The advantages of the red rubber tubing are that it is soft, non-irritating, and possesses just sufficient resistance to enable it to be passed through the nose by itself, thus dispensing altogether with the use of an instrument, the passage of which, as for instance in plugging the nares is, as is well known, a source of much discomfort and annoyance to the patient.—*Med. Record.*

#### Ether in the Treatment of Sore Throat.

Professor CONTALO employs an ether spray in the treatment of pharyngitis. The applications are made several times a day, according to the gravity of the case. Under their influence, it is claimed, the temperature falls, the vessels contract, and the local condition is speedily improved. In two cases a fibrinous exudation was detached and not reproduced. Ether, according to the author, deserves a trial in pharyngeal diphtheria, not only as an antiseptic agent, but also because the pain is thereby greatly diminished, and the taking of nourishment facilitated. Two cases of pseudo-membranous pharyngitis were successfully treated by this method. He insists especially upon the rapid lowering of temperature following the

applications of ether spray.—*Journal de Médecine de Paris.*—*Ibid.*

#### Nasal Catarrh.

Cubeb is the remedy most relied on in the Throat room for constitutional impression in the ordinary form of the complaint. Fifteen or more drops of the oleo resin, on sugar, after meals; or a few grains of the recently prepared powder, with two or three grains of salicylate of cinchonidia, in pill or capsule, are the forms in which it is usually prescribed. Cleanliness, by douche or spray, is essential in giving the parts a chance to get well, which they often will do by cleanliness alone, without any topical medication.—*Polyclinic.*

#### Hæmoptysis.

Dr. ARNOLDOW relates (in *Deutsche Medicinal-Zeitung*) the case of a man suffering from hæmoptysis, who was also threatened with delirium tremens. Chloral had been given for the sleeplessness, but without effect. Upon the administration of ergotine, not only did the hemorrhage cease, but the symptoms of alcoholism also subsided. This happy result induced the author to give ergot in several other cases of mania-a-potu, in all of which the delirium was speedily controlled. Dr. Arnoldow explains this action by the contraction of the blood-vessels of the brain induced by ergot.—*Weekly Med. Review.*

#### Tubercle-Inoculation.

From a series of experiments upon tubercle-inoculation, and the effects upon the process by different disinfectant agents, M. VALLIN has found sulphurous acid the most efficacious in preventing contagion. He therefore recommends that, in hospital wards where the air is infected by tuberculous patients,

from time to time the rooms should be vacated and thoroughly fumigated with sulphurous acid.—*Ibid.*

#### Hæmoptysis.

Dr. BROWN says: Of drugs, ergot seems to be the most powerful in checking hæmoptysis. Thus the extractum ergotæ fluid may be given in doses of a teaspoonful every fifteen minutes, until the hemorrhage is stopped, and then continued in smaller doses, or it may be given by hypodermic injection, in doses of fifteen drops, or ergotine may be used. If the stomach is irritable, ergotine may be given, per rectum. Sometimes ergot will have no appreciable effect. Under such circumstances I think that gallic acid is the next best remedy. I frequently combine it with sulphuric acid, which makes a more efficient and pleasant mixture:  $\mathcal{R}$ . Acidi gallici, 3 ij; acidi sulphurici aromat., 3 j; glycerinæ, 3 j; aquæ, q. s. ut. ft., 3 vj. M. Sig.—A tablespoonful, as required. This is to be given every half hour or at shorter intervals, until the hemorrhage is brought under control. This, I think, ranks next to ergot, and where the stomach refuses ergot, or where ergot produces no effect, I usually resort to this combination.—*Med. Brief.*

#### Bleeding Coup-sur-Coup in Pneumonia.

Not long ago Professor HARDY, in his clinic at La Charité, protested against the unreasonable prejudice against all venesection which has taken the place of its former extravagant adoption. His audience seemed almost astonished at his presenting to them a case in which he had performed bleeding for pneumonia three times in the twenty-four hours, and that in the very theatre in which Bouillaud formerly so warmly advocated the *coup-sur-coup*

practice, since almost forgotten. The subject of the case was a man of thirty-seven years of age, of good constitution, and in the enjoyment of good health until four days prior to admission, with well-marked signs of acute, fibrinous, lobar pneumonia of the left side. In presence of this case of uncomplicated pneumonia occurring in a man in the prime of life and of good health, and who had no morbid antecedents except two similar attacks some years before, Professor Hardy ordered 400 grammes of blood to be drawn at once, 400 in the evening, and 300 next morning, so that 1,100 grammes were taken in the twenty-four hours, and a somewhat abundant epistaxis followed some time after the last venesection. After the third bleeding the condition of the patient was greatly improved. The oppression of the breathing was relieved, and the cough and expectoration were sensibly modified, the temperature descending first to 39° and then to 38° Cent. Next day all fever had entirely ceased, the temperature being 36.8°, the pulse 80, and the respiration 18; the cough had disappeared, and the expectoration, which persisted awhile, was white and fluid. The local signs decreased in like manner, so that on the second day there scarcely remained a slight dulness and obscurity of respiratory sound at the base, respiration being quite normal throughout the rest of the lung. This rapid disappearance of the local signs was, in fact, one of the most special and remarkable facts of the case, when we remember how frequently such signs are found to persist for several days after the complete disappearance of fever and the general symptoms. In this case the disappearance was almost simultaneous; and Professor Hardy attributes this favorable result to the bleedings practised after the method of

his great predecessor. But while treating the patient in this manner, Professor Hardy had the case of a colleague under treatment, in which the conditions of the patient's general state and local lesion were quite different, and in which blistering, Todd's alcoholic mixture, tonics and reconstituents were the means required, and were followed by complete success—*Medical Times & Gazette*.

#### Inspection of the Throat without Instruments.

Dr. SAMUEL W. FRANCIS, of Newport, R. I., writes that very often it is difficult to depress the tongue of a patient who is suffering from sore throat, diphtheria, follicular tonsillitis, or other affections of the fauces, etc., and suggests that they be told to open their mouth, in front of a good light, and simply, but with force, say: *Arh! Barrh!! Varrst!!!* LIFE—enunciating each word some few seconds. Dr. Francis has tried this, and not only obtained an excellent view, but the different positions of the uvula and surrounding parts, greatly assisting the diagnosis and treatment of the disease.—*N. Y. Med. Journal*.

#### DIGESTIVE TRACT.

##### Eserine in Diarrhea.

Dr. Eschle, in the *Neurologisches Centralblatt*, reports observations made in the Richterschen Heilanstalt (Boston Medical and Surgical Journal) on the curative effects of calabar-bean preparations in catarrhal conditions of the digestive tract. Eserine (physostigmin) the alkaloid which with calabar is found in the seed of the *physostigma venenosum*, was used some time ago in the same institution, where it gave great satisfaction in quieting maniacal patients, and for such paralytics as were

not liable to apoplectic attacks. The action of the drug proved similar to, though more lasting and reliable than that of hyoscyamin. The method of exhibition was by the subcutaneous injection of a one-half per cent. solution of sulphate of eserine in doses of .001 gram to .0015 gram. Its use was found to be always attended by alteration in the digestive organs. One maniacal patient who cried out continuously, was quieted by the use of .0025 grams; this rather large injection caused vomiting and free watery stools. The use of smaller doses quieted the psychical and motor restlessness, and produced sleep without vomiting or defecation. In three other patients (paralytic) a stoppage was noted for over thirty-six hours, vomiting occurring only once. Quiet in bed was always ordered. The special object of the communication was to report the results of the use of eserine in three cases of intestinal catarrh.

The first patient suffered from an attack of this nature, causing continual desire to defecate, with a passage every half hour during the second day. Hypodermic injection on this day of .001 gram of the eserine solution produced sleep in an hour and a half which lasted from two o'clock till evening. No passage occurred until forty-six hours after the injection.

In the second case intestinal catarrh was brought on by a cold. A large number of watery stools were passed during the night and on the following morning. The same dose was administered at 10.30 A. M. The patient complained of general weakness and of numbness in the arm in which the injection was made. The pulse was slowed, but remained moderately strong. At four P. M. a watery passage occurred, after which none until twenty-seven hours after the injection, followed by

stoppage of thirty-six hours; there was no vomiting. The patient was quite comfortable on the evening of the day of the injection, having passed the afternoon half asleep.

The third patient, a man of thirty-nine years, suffered from chronic dysentery, acquired in Africa. On the day before the medicine was used, twenty-four bloody stools were counted by the attendants. On the day of the first injection (.001 eserine sulph.) twelve stools were passed, of unchanged character. During the twenty-four hours following the second injection (.0015) there were five passages striped with blood, and during the next twenty-four hours four bloody stools. In the two days following the third injection (.0015) seven stools were passed, of which three were accompanied by blood. During the four days following the fourth injection (.0015) the passages varied from one to six, some with and some without blood. Vomiting followed the first two injections only. The writer remarked that, although the last case was not watched to its termination, and although he could not promise himself a perfect cure, the result was sufficiently marked to illustrate the beneficial action of the drug in this dose in limiting the weakening hemorrhages and albuminous stools.—*Louisville Medical News*.

#### Oxide of Zinc in Chronic Diarrhœa.

M. GUBLER has found it most useful in the diarrhœa of phthisis, and whenever ulceration of the uterus is suspected. He gives it in powders in the form:  $\mathcal{R}$  Oxide of zinc, xxx grs.; bi-carbonate of soda, x grs. In four powders, two or three daily.

### Apomorphia a Safe, Certain, and Quick Emetic.

In the *Brit. Med. Jour.* Mr. BROWN, L. R. C. P., of Bacup, writes:

It has occurred to me in several cases to have patients who have been obnoxious to ordinary emetics. The emetic has caused nausea and depression, but no emesis. A few weeks ago two cases of this kind occurred in my practice. One was a man who had been drinking and eating indigestible food. Domestic emetics were given, which had produced nausea and ineffectual attempts at vomiting. It occurred to me that apomorphia, used hypodermically, might succeed. I prepared a solution containing a grain of chloride of apomorphia, twenty minims of rectified spirit, and water to two drachms, of which I administered ten minims hypodermically, which equals one-twelfth of a grain. In seven minutes it produced free and copious vomiting. There was no nausea, nor depression, nor intolerance of food. The other case was a man who was a total abstainer. Patient had loaded his stomach with a mass of indigestible food, which had caused acute pain in his stomach. He had tried domestic remedies without success. Pain was so severe that I was called up at night. The other case having been so successful, I at once administered ten minims of the solution. In two minutes, without any previous nausea or warning, the contents of the stomach were violently ejected on the floor, the patient not having time to get a vessel to vomit into. This was repeated two or three times at short intervals, and the patient had speedy relief. In this case there was no nausea or bad after-effect.

From inquiries which I have made, I am convinced that the value of apomorphia as a safe, certain and quick emetic

is not appreciated because not known. In cases of alcoholic and narcotic poisoning it is a most valuable remedy; and, judging from my experience in one case, the emesis is delayed but a few minutes. In cases of acute gastralgia and convulsions in children, due to overloaded stomach, apomorphia will prove a speedy cure. I have given one-sixth of a grain of the drug to children by the mouth without producing any effect whatever.—*Med. and Surg. Rep.*

### Epilepsy caused by Intestinal Worms.

The following case is reported by Dr. WINDELSCHMIDT, in the *Allgem. Med. Central-Zeitung*:

A woman, forty years of age, had suffered for six years from convulsions, epileptic in character, which were steadily increasing in frequency, until finally the attacks appeared every evening as soon as she lay down, lasting several hours and returning again toward morning. Upon questioning, it was ascertained that she was troubled with large numbers of ascarides in the rectum and vagina. Vaginal and rectal injections of a bichloride of mercury solution were ordered, and in five days the attacks had wholly ceased. They returned once again upon the re-appearance of the worms, but ceased after a few injections, and have never since troubled her.—*Medical Record.*

### In Flatulence,

Dr. BRUEN prescribes a pill containing five grains of bicarbonate of soda and five drops of oil of eucalyptus two hours after meals. Pepsin or pancreatin with milk food and the mineral acids with meats should be directed to be taken immediately after meals.—*Weekly Med. Review.*

# CONSTITUTIONAL DISEASES.

## Good Remedies out of Fashion.

In an address on this subject, recently delivered by Dr. C. J. HARE, the lecturer made some interesting observations on emetics and bleeding (*British Medical Journal*). In former times it was not unusual to commence the treatment of many diseases with the administration of a dose to procure vomiting. And although the remedy might then be given sometimes indiscriminately and according to routine, only those who had seen the effects of emetics, properly and judiciously given, could conceive the beneficial effects they sometimes produced. In the early stage of an attack of croup it was by no means unusual to give an emetic of tartarized antimony or of ipecacuanha. And it was in accordance with the recorded experience of some of the best authorities and most practical men, and quite consonant with his own experience too, that symptoms which presented the most certain augury of a severe attack were by these means cut short, the hoarse voice resumed its natural character, and the feverish symptoms were in a few hours relieved. He knew quite well that a great fear was entertained by some as to the depressing effects of emetics. But the fear was theoretical, and not practical; and those who had had most experience in the administration of them best knew how groundless the fear was. In diphtheria, too, he had seen the false membranes which were out of the reach of local remedies, and which the patients coughed and coughed in vain, and utterly exhausted themselves to get quit of, readily brought up by the action of vomiting, to the immense relief of the sufferer. "In suffocative bronchitis," the lecturer continued, "the

effect of emetics is sometimes magical, and by their administration in such cases not only is immense relief given, but I am certain that lives are saved. You are called to a patient who has been ill a few days, with increasing dyspnoea; she is sitting up in bed (I draw from nature), for to lie down is impossible; she is restless and tossing about; the lips, and indeed the whole face, blue; the eyes watery and staring; the pulse quick and small; the cough constant; the expectoration semi-transparent and tenacious; over every square inch of the chest, front and back, from apex to base, you find abundance of rhonchi—moist, sonorous, and sibilant ones in the upper part of the lungs, and muco-crepitant or mucous rales toward the bases. Ammonia and stimulants, right and good in their way perhaps, in such a case are too slow in their action—the patient is, in fact, more or less slowly, more or less rapidly suffocating. An emetic of twenty-two grains of ipecacuanha in an ounce of water is given; in ten or fifteen minutes the patient vomits and brings up a huge quantity of that tenacious mucus, and the whole aspect of the case is altered; the distressed countenance is relieved; the breathing is at once quieter; and the patient is able, for the first time for the past twenty-four hours, to lie moderately low in bed, and to get some sweet refreshing sleep. The patient is, in fact, rescued from the extremest peril, and in this case, and in many similar ones too, I believe, from otherwise most certain death. Of course, in such cases the emetic is not given for its effect on the stomach, but for its collateral effect in mechanically clearing out the enormous amount of secretion which accumulates in the bronchial tubes, and which the patient is otherwise quite incapable of getting quit of; and thus the half-choking, almost asphyxiated

condition is changed for one of comparative comfort, and time is gained for the action of other appropriate remedies. No doubt the secretion may, and often will, accumulate again ; and I have not hesitated again in bad cases to repeat the same good remedy ; but it is a fact, and a very positive one too, that quite contrary to what those who have had no experience in the plan suppose, the system rallies instead of being more depressed under the action of the remedy.

There is a class of cases in which the right heart is engorged with blood, and in which the only hope of rescuing the patient from death is by bleeding. A man of middle age (I again draw from nature) has considerable chronic bronchitis, with some congestion of the lungs, and, like many other unwise persons, he goes to a southern watering-place, instead of remaining in his room and in an uniform temperature. Becoming worse, he determines to return home, and travels on a cold spring day; his dyspnoea is so much worse on the journey, that his friend and the fellow-passengers doubt whether he will arrive home alive ; and when his carriage meets him, it is with the greatest difficulty he is conveyed to his house and got into his drawing-room. You are at once sent for, the message being that the patient is dying, and when you arrive you find that that is the fact. He is sitting in a chair (to lie down is impossible for him), his face is blue and swollen, his lips purple, the eyes suffused and staring, his heavy gasping breathing you have only too distinctly heard and recognized as you ascended the stairs, and when you see him you find his chest heaving, and each short gasping inspiration followed by a long wheezing and moaning expiration ; his lungs are full of moist, sonorous and mucous and submucous rhonchi, and

scarcely a trace of vesicular respiration is to be heard, and he is pulseless. He looks to you beseechingly, and gasps out, in scarcely articulate words, that he is dying. This is but too true. Now, the treatment for such a condition at the present day is "to pour in stimulants" (though the patient can scarcely swallow). Brandy and water are given, and ammonia, and perhaps ether ; then, if the patient live long enough to have them made, mustard poultices are applied to the chest, and to the calves, and to the feet, and the patient is fanned, and the patient dies. Something has been done, but that which true pathology—and, indeed, common sense, unshackled by prejudice, custom, and fashion—would dictate, has been left undone. Appearances have been saved, but not the patient's life. The fact is, that here the danger lay in the right side of the heart being gorged with blood, so that it was impossible for its stretched and distended walls to contract and to propel forward the thick and blackened blood. Relieve that poor oppressed, distended heart, and all may be well. Open one of those veins which are, with every systole of the heart, tending to carry more and more blood to this already distended right ventricle, and all may yet be well with your patient. Sometimes this blood-letting, in extreme cases, is no easy matter ; it may be necessary, before you can effectually open the vein, to place the patient's arm in warm water, so as sufficiently to distend the vein ; and even when the ligature has been efficiently applied, and the vein well opened, you may have to press and squeeze and rub upward the arm before a drop of the thick and tarry blood will flow. But, when it *does* flow at length freely, what a marvellous change may you see take place !—the breathing becomes quieter, deeper, and

less noisy, the haggard face resumes the appearance of tranquillity, the blueness of the skin is replaced by a more natural tint, the pulse becomes more and more distinct, and, in a word, the choked-up heart is set free."—*Med. Record.*

#### Salicylate of Bismuth in Typhoid Fever.

PROF. HENRI DESPLATS, after a careful study of the antipyretic action of carbolic acid, salicylic acid, salicylate of soda, and resorcine, has demonstrated that these agents have an influence on the temperature and other elements of fever, whatever may be the nature and cause of the fever (typhoid, puerperal, variola, intermittent fever, erysipelas, rheumatism, pneumonia, etc.); that this action is sure and prompt when these drugs are administered in sufficient quantities; and that it is quick, causing rapid elimination. He then studied the accidents which these agents have been said to produce (collapse, convulsions, albuminuria, melanuria, etc.), and has established that they do not cause pulmonary congestion or renal lesions, and may be administered in albuminuria; that, if administered in too large quantity, they may cause collapse, but this collapse is rare and not dangerous; that in very rare cases, when given in enormous doses, they will cause convulsions, but these have never terminated fatally.

He now gives the results of his experiments with salicylate of bismuth in typhoid fever. He has administered it in twenty cases. It is more readily taken than salicylate of soda, being less soluble and therefore of less pronounced taste. It consists of salicylic acid 2 parts, bismuth 1 part, although it keeps more readily if there is an excess of 3-4 parts in the 100 of salicylic acid. It may be given in unleavened bread or slightly aromatic syrup of acacia, in

doses of grs. xv-xxx, though he has given from  $\mathfrak{D}\text{iv-}3$  ijss in a day. A little seltzer water may be given immediately after it to enable the stomach to retain it better, if that organ be very irritable. It is always advisable that a more or less considerable quantity of liquid be drunk after each dose. The effects obtained are of two kinds, *immediate* and *remote*.

The *immediate effects* are comparable, when the dose is sufficient, to those produced by carbolic acid, resorcine or salicylate of soda. To observe these, the patient should be closely watched, and the variations of temperature noted. Vulpian's statement that the temperature does not rapidly abate is erroneous, as M. Desplats shows by several cited cases. The immediate effect is never wanting when the dose is sufficient. It produces a less abatement of temperature than carbolic acid, but the sudden rise so often seen after the abatement from carbolic acid, is not observed. Beside the immediate effects, salicylate of bismuth has an incontestable action on the general temperature-curve. As has already been noted by Vulpian, the morning fall of temperature is greater, especially when no salicylate has been administered during the night. Desplats has several times observed that the temperature continued to abate during the forenoon, when the patient had taken no medicine, and thinks it very likely that these late effects are due to absorption of the drug, which is not very soluble. Sometimes, instead of a fall of temperature, he has noticed abundant perspiration coming on during the forenoon, long after the last dose of salicylate; this seems to confirm the hypothesis of late absorption.

*Remote effects.*—It is important to know what action the salicylate of bismuth, regularly administered, exercises on the evolution and termination of the

disease. Twenty cases are not sufficient from which to draw general conclusions, but they may be of service in drawing conclusions from an additional number of cases. Desplats divides his cases into three groups: The first includes the cases in which the fever was arrested, in which it may be said that the drug had an abortive action; the second group includes those cases in which the effect was signal, but not so marked; and the third, those cases which were rebellious to treatment, either terminating in death, or seemingly uninfluenced by the drug. Eleven cases are reported in which it had an abortive action. Vulpian has already observed one case in which the fever was arrested on the fifteenth day by salicylate of bismuth. He hesitated to attribute this effect to the drug, as the rose spots were absent. This does not negative the diagnosis of typhoid fever, however, as cases do occur in which the rose spots are absent. Four cases are recorded in which the action of the salicylate was less pronounced; and five cases, all very severe, two recovering, in which there was no apparent effect. In all, twenty cases are recorded. Epistaxis was a rare symptom, and was in no case abundant. Intestinal hemorrhages occurred in two cases, one of which recovered. Delirium was rare, in one case being attributable to the medicine; this was rather subdelirium than true, and there was also deafness. When large doses, 3 ij-3 ijss, were given in three or four hours, there was, in some cases, a depression of the vital forces, which passed off when the drug was discontinued. The best results were obtained with doses of 3 iv-3 jss.—*Bulletin Gén. de Thérap.*

#### Liniments in Muscular Rheumatism.

The following preparations are recommended in a recent issue of the *Gazette*

*Médicale de Paris*: R. Saponis, 3 jss.; ætheris acetic, 3 j.; camphoræ, 3 j. M. or, R. Tr. aconit. rad., m. l.; ung. simplicis, 3 j. Misce bene et adde. R. Chloroform, 3 ss.; Morphine hydrochlorate, gr. ½.

#### Acute Rheumatism as a Premonitory Sign of Phthisis.

Basing his observation on four cases, Dr. JOHN ALFRED AUSTIN (*Lancet*) asks whether acute rheumatism may not often be due to commencing phthisis, to a tubercular deposit in the synovial membranes, setting up inflammation. His cases are too few to formulate any rules of kinship, but his suggestion is worthy of more extended observation.

#### Vohsen: Acute Rheumatism.

KARL VOHSEN, in an interesting article, discusses first the many theories as to the etiology of rheumatism, finds most of them untenable or unsupported by any definite facts, but leans rather to the belief that it is an *acute infectious disease*, due probably to micrococci in the blood. The many complications are discussed in relation to this point.

Childhood suffers from all the complications of acute rheumatism which befall adults. Paralysis of the muscles of the eye is the only one the author has not seen in children. But still rheumatism in children has its own characteristics. The severity and duration of the pain is less on the average than in adults, the duration in adults being two or three weeks, and in children five to eighteen days. The complications in children show still greater differences. Chorea, a frequent complication in early years, is exceedingly rare in adults. Heart affections are very much more frequent in children. From his own cases and from the records of many

others, the author finds that the heart is affected in nearly fifty per cent. of cases in children. This complication is as apt to occur in mild cases as in severe ones, in fact, some authors think it more frequent in the subacute cases.

The author then analyzes twenty cases which had recently come under his notice. The ages were between nine and fourteen years. No deductions as to hereditary influence or sex could be fairly drawn. In nine cases there was endo- or pericarditis. In none of these was the fever at any time above  $103.2^{\circ}$  F., and in one case there was no fever.

Swelling of the joints was observed in three cases. The pain was severe, but of short duration. In all cases the salicylate of soda proved promptly effective against the affection of the joints, but had no effect on the development of the cardiac complications. These occurred in about half of all the cases. The mitral valves and the pericardium were most frequently attacked. The lighter forms of rheumatism seemed especially to predispose to the heart troubles, making examination of the heart necessary in all cases.

As to why the heart is affected in children more often than in adults, the author can offer no explanation. Anatomy and physiology give us no theories. The noduli, Jacobi's narrowness of the aorta, and other anatomical points of difference between the child's and the adult's heart, have disappeared before the age at which rheumatism is frequent. The author then argues that the best theory to explain it is that rheumatism is an acute infectious disease, and attacks the heart of the child more often on account of the less power of resistance it has. Further, exactly this relation of the heart to acute rheumatism is an argument in favor of its

infectious origin. Of forty-five cases of endocarditis in childhood, reported by V. Dusch, fifteen were idiopathic, twenty were connected with acute, two with subacute rheumatism, and the remainder were complications of outspoken infectious diseases—scarlatina, variola, syphilis congenita. The acute rheumatism, therefore, so far as the heart complication is concerned, would seem to class itself with these acute diseases. Further, the rheumatism especially causes the heart complications, because its affection especially attacks synovial membranes, and because there is so marked a parallelism between synovial membranes and the endocardium. All the darkness which surrounds the development and course of acute rheumatism is not removed by the supposition of a specific virus, but the author claims that not only has the theory good facts for its support, but also it explains more of the symptoms and complications than any other theory which has been offered.  
—*The American Journal of Obstetrics.*

#### **Tubercular Cerebro-Spinal Meningitis.**

Dr. J. T. ESKRIDGE, in an elaborate article read before the College of Physicians of Philadelphia, and published in the *Med. and Surg. Reporter*, comes to the following conclusions:

1. Tubercles occur in the membranes of the brain and cord, but they are more frequently found in the former than in the latter situation.
2. Tubercular deposit may first take place in the meninges of the cord and then extend to those of brain, although the reverse is the rule.
3. Tuberculosis of the cord, contrary to the views of Rendu, has more than an anatomical interest.
4. Tubercular cerebro-spinal meningitis gives rise to special symptoms, and by a careful analysis of a number of cases it may be recognized.
5. It is probable that

many cases of so-called sporadic cerebro-spinal meningitis, that have a duration of several months and then prove fatal, are tubercular in character. 6. Paralysis or contractions may be due to brain or spinal lesions, or to both. 7. When cerebral fever simulates the periodic manifestations of malaria, the lesion is probably in the membranes or cortical substance of the brain, or in such a position as to exert pressure upon these structures. 8. Ventricular effusion probably does not give rise to paralysis or contractions; the former motor disturbance in these cases being due to softening of motor zones, and the latter to irritation of the meninges of the brain and cord. 9. Repeated microscopical sections may have to be made in certain cases of tuberculosis of the meninges before the nature of the disease is detected. 10. Right or left side of the head may in turn be the warmer, in health. 11. When surface thermometers are used to register the cerebral temperature in disease, the normal averages should be taken from 1 degree to 1.5 degree higher than those given by Gray and others. 12. The head temperature in diseases of the brain may equal or exceed the heat of the axilla for a length of time. 13. In cerebral lesions, the temperature of the head is not marked by those sudden variations manifested by the axillary temperature in these cases. 14. Variations of head temperature in diseases of the brain take place comparatively slowly. The tendency of the heat of the head to remain permanently above the normal, while that of the axilla is normal or several degrees below, is the strongest evidence of organic disease. 15. The thermometer and the microscope in the case reported agreed in locating the greatest inflammatory trouble in the upper cervical portion of the cord. 16. Brain les-

ions attended by congestion or inflammation have a higher local temperature than suppuration going on within the cranial cavity.

#### Diphtheria.

Dr. LEE (*Med. Age*) gives the following as his treatment of this malady: *R.* Resorcin, gr. x.; acid. tannic, 3 j.; acid salicylic, 3 iv.; acid. boracic, 3 ij.; Sulph. pulv., 3 ss. Mix thoroughly, and put a small pinch of this powder on the tongue every two or three hours.

#### A Case of Diphtheritic Croup treated exclusively by Calomel.

Dr. J. R. JONES, Leesville, Mich. On the afternoon of August 27th, I was called to see a patient aged two years and four months, who had been sick about 24 hours previous to my visit. I found a vigorous looking boy with temperature 102 degrees, pulse 125. A yellowish patch was embedded in the right tonsil, and there was a yellowish discoloration of the tip of the epiglottis, and as much of its free margin as I could see. Respiration was much embarrassed, expiration and inspiration being equally difficult, so that his breathing could be heard plainly in an adjoining room. In addition there was a bad, croupy cough, harsh, brassy and frequent. From previous experience with similar cases my prognosis was decidedly grave, and considering it useless to give remedies hitherto resorted to by me in such a case, I determined to give the calomel treatment so strenuously advocated by Dr. Reiter, a fair trial. The following was the treatment and result: A drachm of calomel was divided into 12 powders, and orders given to have a powder administered every hour until free purging occurred. I purposely refrained from giving quinine, iron, brandy, or any-

thing in the way of medicine except milk, so that the calomel would have fair play, and stand upon its own merits, if it had any, of which however I had little faith. Next morning I called again, and was pleased to find my patient living, but apparently the child was no better; I thought, indeed that he was rather worse, for there was a decided drowsiness and cyanosis. The powders had all been given, and some time had elapsed after giving the last one before the bowels moved, when there was a copious evacuation of black, foul-smelling fæces. About three hours later there was another passage, but the discharge was much thicker and greenish in color. I left six more powders to be given as before. Called again that evening and found bowels had moved twice, the discharges being of a dark green color, of the consistence of jelly, and passed without any pain. There was no evidence of pain at any time. Patient looked brighter, the cough was much less frequent, and I thought looser. Thinking patient had calomel enough, I gave the following prescription: *R. Fl. ext. ipecac., gtt x; tr. belladonnæ, gtt xx; spts. etheris nitrosi, 3 j; aquæ, 3 iij. S. A teaspoonful every hour.* Called again next morning and found patient sitting up in bed, looking bright and well. Breathing was easy and noiseless; temperature normal, pulse 120. Cough infrequent and loose. The patch on tonsil was still visible, but diminished in size and thickness. Only one or two doses of the above prescription had been given, as the child cleared its windpipe of a large amount of stringy-looking stuff (so described by the parents) soon after I had left, after which he breathed freely and fell asleep, resting well all night afterwards. I then left the following prescription: *R. Ammoniac carb., 3 ss;*

*syr. senegæ, 3 ss; spts. vini gallici, 3 j; syrup. simp. q. s., 3 iij. S. A teaspoonful every three hours.* The child has made a rapid recovery. I have given the case in detail, and I have but few comments to make, and no theory to advance. I looked upon the case as a hopeless one to start with, at least under ordinary treatment. The amount of exudate in the pharynx was trifling, but the glandular enlargement of the neck considerable. There was no hypercatharsis following the drachm and one half of calomel. No medicine whatever was given unless as herein detailed, nor was the throat seamed or an atomizer used. Monsel's solution was applied with a camel-hair pencil, a few times, to the patch on tonsil, but that could not affect the larynx.—*Med. Age.*

#### Lactic Acid in Diphtheria.

Dr. J. P. LYTLE reports favorable results with a spray of lactic acid in diphtheria. He says that it rarely fails to dissolve the membrane in two or three applications. The solution used was of the strength of lactic acid, gtt. xxx.; aquæ, 3 i.

#### Perchloride of Iron in the Treatment of Typhoid Fever.

M. E. DINAUD (*Union Médicale*) advocates the use of the perchloride of iron, not only in diphtheria, but also in typhoid fever. [In diphtheria he claims for it a specific action.] Although he does not pretend that the iron is a specific in typhoid fever, he believes it to be of great efficacy, not only in adults, but in children. No single remedy so tends to relieve the impoverished condition of the blood, the torpor of the stomach, and the inflammatory and ulcerative changes of the intestine that characterize the period of decline. Some

patients complain that liquid perchloride of iron causes a painful sensation in the pharynx, which they compare to that of a burn. If objection is made to it on this account, the dry perchloride may be given instead. This is now to be had in the form of *dragées*, a very acceptable preparation for administration. To children a drop of the liquid, well diluted, may be given in broth or in gruel, as often as the latter is taken. The remedy should be begun at the end of the second week and continued until convalescence is complete.—*N. Y. Med. Journal*.

#### A Renal Form of Typhoid Fever.

Dr. DIDION has chosen this subject for an inaugural dissertation, and comes to the following conclusions: Typhoid fever produces a renal congestion, which plays an important part in the course of the disease. Albuminuria is almost constant, but generally slight and temporary; when abundant, it is a sign of true nephritis. The real inflammation is both parenchymatous and interstitial, and produces certain characteristic symptoms, such as asthenia, stupor, dryness of tongue, œdema of the face and legs, lumbar pains, cutaneous eruptions (pemphigus, ecthyma, boils), and an alteration of the urine, which has a reddish color and the odor of boiled bread; in the deposit, red and white blood-corpuscles are found, as well as casts; the urine contains a large quantity of albumen. The diagnosis can easily be arrived at by the above-mentioned symptoms. The termination is often fatal, either from asthenia or uræmia. As to the treatment, Bouchard recommends carbolic acid and the salicylates, Polli the sulphites, Klebs the benzoate of potash. Leeches, mustard poultices, and cupping in the lumbar region are useful; but blisters, even

with the addition of camphor, must be avoided. In certain cases the disappearance of the symptoms is accompanied by abundant diuresis, which ought, therefore, to be favored if possible; but all diuretics are not equally good, those which possess irritating properties must be avoided. The best in these cases is milk, pure or mixed with water. Whatever may be the way in which it acts on the kidneys, it is always well borne, and its action is double; it increases the secretion of urine, and hastens the elimination of toxic principles, without producing any irritation, even in the most acutely inflamed kidney. Subcutaneous injection of pilocarpine might perhaps be useful; in one case, when the skin was dry and burning hot, Dr. Didion injected twice daily one-sixth of a grain of pilocarpine, and under its influence the skin became moist and abundant sweat was produced; the tongue also was less dry than before; the temperature fell in two days from 105.8° to 98.6° F.; but three days later the patient died, after the temperature had once again reached 104° F. New investigations are necessary before we can arrive at definite conclusions. As for the cold baths, Gubler thinks that they are contra-indicated in case of nephritis, but Libermann considers their use as surely beneficial in spite of it. Several patients who had been subjected to that treatment did not complain of any inconvenience, and cold lotions rapidly applied to the trunk and limbs with a sponge seem to relieve the patient, lower the temperature, and re-establish the functions of the skin. All these advantages must be weighed against the danger of a renal congestion; but further experience alone can show which treatment is most advantageous.—*British Medical Journal*.

**Malarial Laryngitis.**

In *Rev. Med. Franç. et Etrang.*, Dr. E. BRIAND concludes that: 1. There exists a form of laryngitis due to malaria, characterized by congestion of the larynx, giving rise, from a symptomatic point of view, to the functional signs of true croup. 2. This variety of laryngitis differs from laryngismus stridulus by the symptoms, course and prognosis, and generally yields to treatment by sulphate of quinine. 3. It is not very rare in infants, and may be recognized by the fact that it is preceded or followed by malarial manifestations.

**DISEASES OF THE NERVOUS SYSTEM.**

**The Cephalalgia of Adolescence.**

The *Gazette des Hopitaux* notices a recent publication of Dr. RENÉ BLANCHE, under the title of *Cephalalgie de Croissance*. This, of course, is no new condition, for most practitioners must have met with examples of it more or less frequently, and have generally given it only the significance of a mere symptom. But for Dr. Blanche it constitutes in some cases a definite morbid condition — special disease of adolescence. It is a persistent cephalalgia, accompanied by various disturbances of the nervous and circulatory systems, more or less fleeting giddiness, and sometimes attempts at vomiting. These may return daily for months, not at the same time of day, but at any time that the patient undertakes intellectual labor of any continuity requiring a certain amount of attention. It has been generally in subjects from ten to eighteen years of age that Dr. Blanche has met with this form of cephalalgia, which occurs alike in young boys and girls, but most frequently in the former. The

seat of the pain is usually confined to the forehead, but sometimes it corresponds to the whole hairy scalp, from the vertex to a circular line passing on a level with the orbits and mastoid process. The pain is never unilateral, as in true migraine. At the same time a change of disposition takes place, the subject becoming nervous and irritable; but the inaptitude for work is the most constant and uniform symptom. The practitioner in such a case may find himself in a somewhat delicate position; for while, on the one hand, he may have to suspect a simulated affection, all the symptoms of which are subjective, he may, on the other, have to do with only a too real affection. Great attention to the case, a strict surveillance of the young persons who complain of the pains, the persistence of these and their resistance to the usual remedies, will in the end lead to a conviction of the reality of the affection. Its duration is not for a few days only, or even for some weeks, but for months and even years, so that simulation would be difficult indeed. The inaptitude for intellectual labor, so far from being made a pretext for idleness and amusement, often becomes with these young persons a subject of poignant regret. Besides these cases of cephalalgia, which are temporarily produced under the influence of efforts at intellectual work which surpass the strength of the scholar, and which may be regarded as the benign and usual form of the affection, Dr. Blanche refers to other cases, in which the cephalalgia is constant, and undergoes exacerbation whenever mental exertion is attempted. Cases of this kind seem to be especially connected with diathetic heredity; and among the cases reported are those of young persons the issue of arthritic or neuropathic parents. Dr. Maurice Perrin, consulted in some

of these cases, has offered the opinion that most of the subjects of this cephalalgia suffered from hypermetropia or astigmatism, and that these pains were especially, if not exclusively, attributable to the attempts at accommodation of the eye. But Dr. Blanche, while admitting the possible concurrences of these disturbances of vision, has met with cases in which the employment of appropriate glasses exerted no beneficial effect, the cephalalgia being quite independent of the condition of the eyes. Active life in the open air, the use of appropriate glasses when visual trouble exists, and, above all, the absolute cessation of intellectual labor for a prolonged period, have proved, together with hydrotherapia, the sole means which have given any relief, and sometimes have caused the disappearance of pains which are often so severe as to render existence miserable.—*Medical Times and Gazette.*

#### Cannabis Indica.

Dr. WILLIAM STRANGE (*Brit. Med. Jour.*), has great faith in this drug as a nervous sedative, for the relief of anxiety and restlessness, but he thinks that it is seldom given in sufficiently large doses. He recommends a grain of the extract, or from twenty to thirty minims of its tincture. It may be advantageously combined with bromide of potassium.—*Med. and Surg. Reporter.*

#### Prof. Nothnagel on the Treatment of Chorea.

In the course of a clinical lecture on chorea, Professor H. NOTHNAGEL remarked that when the disease followed articular rheumatism, salicylate of soda was given; but this treatment had to be pursued empirically and carefully, as nothing was yet known of the nature of the disease. (*The Medical Press.*)

Opiates had no effect, neither had calabar bean. Now-a-days potassic bromide was almost always given, but without any good result. As calmatives, and for the purpose of procuring sleep, morphia and chloral might be given. He had convinced himself by numerous experiments that propylamine was useless. Arsenic, in the form of Fowler's solution, was still the most effective remedy. It could be given by itself or in water. He suggested the following: R. Liq. Fowleri, grm. v.; aq. distill., grm. xv. M. Five drops to be given in a tumbler of water immediately after meals, and the dose to be increased by three drops every day until it reached thirty drops, after which it was to be slowly diminished. The constant current was another effective remedy in chorea, combined with tepid bathing or the application of ice-bags to the spine.

#### For Cramps.

In the *Brit. Med. Jour.* a correspondent recommends the following for cramps: Extract of hyoscyamus, 3 grains; camphor, 2 grains; bromide of morphia,  $\frac{1}{12}$  grain, in a pill at bedtime; while another writer claims good results from small doses of bichloride of soda.

#### DISEASES OF CIRCULATORY ORGANS.

##### Influences of Disease on the Size of the Heart.

From the *Practitioner* we learn that this subject has been investigated by Dr. SPETZ. He finds that in typhus there is no characteristic change in the dimensions of the heart and the large vessels; the same is the case in puerperal pyæmia. In phthisis the heart is diminished, and especially the left ventricle. The right ventricle is often somewhat diminished, but not in proportion

to the diminution in the weight of the body. It is sometimes even hypertrophied, but not as a rule. The ratio between the depth of the left ventricle and the circumference of the aorta is diminished, and as this is not compensated for by hypertrophy of the muscular walls of the ventricle, there is a diminution in the arterial tension. Consequently the pulse in phthisis is soft and small. In cancer the depth of the left ventricle is still more diminished than in phthisis, and the right ventricle is affected almost as much as the left. In granular kidney, both ventricles increase very much, but especially the left. The aorta is not correspondingly dilated. In consequence of this the tension in the arteries is very greatly increased. In myo-carditis, also, the heart is dilated and hypertrophied, but the left and right ventricles are almost equally affected. In chronic emphysema both ventricles are much dilated, with very little thickening of the muscular walls. Both ventricles are nearly equally affected. The pulse is full, but small and languid.—*Deut. Archiv für klin. Med.—Med. and Surg. Reporter.*

#### A Formula for Use in Irregular Heart Action.

In a discussion upon heart disease before the Boston Society for Medical Improvement, Prof. BOWDITCH said that he had found the following formula of great service in relieving even the most serious cardiac affections. He had used it for the last twenty-five years: *R.* Pulv. digitalis, gr. x.; pulv. colchici sem., gr. xx.; sodii bicarbonatis, gr. xxx. *M. et. div. in pil. No. 20.* These are to be taken three or four times daily at first; subsequently to be reduced until only one is taken at bedtime; the treatment to be continued for three to nine months.—*Boston Medical and Surgical Journal.*

#### Iron in Heart Diseases.

According to statements published in his work, to cases reported by his pupils, and to comments made by the *French Medical Press*, few physicians have been as successful in treatment of cardiac affection as Dr. CONSTANTINE PAUL. In cases of hypertrophy of the heart, following lesions of the arch of the aorta (endarteritis), or more remote morbid conditions, as that pathological state of the capillaries frequently preceding and always accompanying chronic cases of morbus Brightii, he found for the anæmia, which characterizes such cases, no medicine as effectual as the following: *R.* Syrup. simplic., 260 (f.  $\frac{5}{8}$  viii.); syrup. flor. aurant., 60 (f.  $\frac{3}{4}$  xv.); ferr. citr. ammon. pyrophosph., 3 (gr. xlviii.); solut. Fowleri, 1.50 (m. xxiv.). *M. S. Dose.*—Tablespoonful.

#### DISEASES OF RESPIRATORY ORGANS.

##### Œdema of the Ary-epiglottic Folds.

*The Medical News* gives the following as the conclusions of M. GONGENHEIM on œdema of the ary-epiglottic folds, especially in chronic laryngeal affections, as recorded in the *Gazette Médicale de Paris*. 1. Oedema of the ary-epiglottic folds, especially in chronic laryngeal affections, is not always accompanied by dyspnœa. 2. When dysphagia is absent, which is rarely the case, the œdema may be latent, and is only revealed by laryngoscopic examination. 3. On laryngoscopic examination, the œdematous or hypertrophied folds do not touch during the respiratory act. 4. When the patient is told to articulate, the tumefied folds approach each other, but do not cause dyspnœa, and dyspnœa is only caused when the act is pro-

longed. 5. When the folds are very much enlarged and in contact, they are more or less completely immovable and inspiration does not cause dyspnoea, though articulation and prolonged examination produce spasm and dyspnoea very rapidly. 6. In the course of a very pronounced case of œdema of the folds, laryngoscopic examination made at the time of an attack of suffocation enabled him to see that, so far from the folds approaching each other at the moment of inspiration, they separate, though very slightly. The suffocative feeling and dyspnoea were not, then, the result of an approach of the folds to each other, but of a spasm of the cords, probably induced to some degree by the prolonged examination. 7. Sestier's theory, therefore, of these cases of dyspnoea is inexact. 8. The attacks of suffocation and the inspiratory whistling are due, in these cases, only to an intercurrent spasm, either of reflex origin or produced by compression of the recurrent laryngeal nerves. 9. The discovery of ary-epiglottic swellings is not a therapeutic indication for tracheotomy, unless there is dyspnoea. 10. It is necessary, in any therapeutic procedure, to touch the tumefied folds only with the greatest circumspection, lest a severe spasm be produced. 11. The spasm is not always, in these cases, an absolute indication for tracheotomy. M. Gengenheim has seen it disappear rapidly in some cases under the use of external and internal remedies. 12. When one sees the signs of laryngeal suffocation, which physicians almost always attribute to an œdema of the folds, a laryngoscopic examination should be made, if possible, as it may reveal the existence of subglottic lesions which may influence the mode of treatment.—*Weekly Med. Review.*

#### **Eucalyptus in the Treatment of Gangrene of the Lungs.**

Dr. BONAMY relates the case of a man about fifty years of age, who was admitted to hospital suffering from cough, dyspnoea, and fever. A few days after admission the fetid odor of his breath became so extreme that it was necessary to separate him from the other patients. There was dullness in the axillary line on the left side over the middle portion of the lung. At this point there was tubular respiration; and crepitant rales were audible at the end of inspiration. The sputa consisted of a black matter, detached portions of which were swimming in an abundant serous fluid. The cough was incessant, and the odor intolerable. A diagnosis was made of gangrene of the lung, of superficial extent. The patient was first put upon a mixture containing carbolic acid, but no improvement following, this was replaced by tincture of eucalyptus. In two days after the last prescription the odor of the breath was much less offensive, and in less than two weeks the patient was cured.—*Le Courrier Médical.*

#### **Iodoform in Chronic Pulmonary Diseases.**

M. SEMMOLA, in a memoir in the *Gazzetta Internaz. delle Scienze Med.*, makes the following observations: It is known that iodoform taken internally is eliminated by the respiratory organs, whence originated the hope that it might have a topic action in such diseases as cheesy pneumonia, bronchial catarrhs and bronchiectasis. Under its influence, expectoration rapidly diminishes, cough is less troublesome, and the products of bronchial secretion, including pulmonary detritus, are disinfected. The fall in temperature may be in great part due to the local antiseptic action on the absorbed putrid products. The daily dose

to be administered should be determined by the tolerance of the individual for the medicament. Where it is not well supported by the stomach, inhalations of spirit of turpentine with iodoform in solution may be used.—*Med. and Surg. Reporter.*

## DIGESTIVE TRACT.

### The Action of Alkalies on Bile.

Some researches have been made recently by LEWASCHEW and KLIKOWITSCH on the subject of the influence of alkaline agencies on the composition of the bile. The experiments were made on dogs with permanent fistulæ leading to the gall-bladder. No canula was used, however. For twenty-four hours previous to the beginning of the experiment neither food nor drink was administered. It was found that artificial and natural mineral water had a similar action on the secretion of the bile. For some time after the administration of the alkaline waters, the quantity of bile flowing from the fistula was diminished. This effect was probably due to the increased flow of bile into the intestines. After this initial period the flow from the gall-bladder became more than the normal. The normal amount had been previously measured. Artificial waters exercised the same influence on the quality of the bile as the natural waters; but different results were obtained with waters of different degrees of concentration. Thus, carbonate of sodium had a more rapid, powerful, and lasting influence on the composition of the bile than the sulphate of sodium. Solutions of weak strength were more powerful than those of higher concentration. Hence, those mineral waters whose principal constituent was carbonate of sodium had the

greatest influence on the composition of the bile, especially when the carbonate was not present in a high degree of concentration. The higher the temperature of the fluids ingested, the earlier and more marked were the effects.—*Centralblatt für Klin. Med.*—*Med. Record.*

### The Treatment of Atonic Dyspepsia.

In an article on atonic dyspepsia (*Med. Record*), Dr. J. MILNER FOTHERGILL thus discourses on the question, What is it which needs improving, the assimilation of hydro-carbons or the assimilation of albuminoids, or both?

"This is a matter too little insisted upon. Too commonly action is taken rather blindly, and malt extract (diastase), or pepsin, or pancreatic preparations prescribed without that discrimination which is so desirable. My own rule, so far as it is formulated, and it needs some corroboration (possibly some correction), is taking the following direction: When the patient is spare and too thin, then starch and sugar are indicated, and diastase should be added to farinaceous matters. Surplus sugar is laid down in the body as fat, that is, within the storing capacity of the organism. Then when there is any tendency to glandular degeneration, and that growth of lowly connective tissue spoken of commonly as tubercle, the indication is some fat which can be assimilated, of which cream, butter, and cod-liver oil are the most digestible forms. When it is desirable to increase the power of assimilating fat, there are several measures which may be adopted, singly or together. There are agents which stimulate the flow of bile, which emulsionizes fat so that the pancreatic secretion may further act upon it, and the most useful of these is ipecacuanha. Ether has been found to stimulate the

flow from the pancreas, and so aid materially in the assimilation of fat. It might be given with liquor pancreaticus and cod-liver oil. Sometimes when cod-liver oil is not assimilated, it is well to resort to the following plan: The oil is observed unchanged in the stools, *en masse*, never having been divided into an emulsion. Here it is well to remember that a fatty acid helps in the emulsionizing of fat. So give some castile soap, say two grains, with two grains of dried ox-gall, in a pill, about two hours after a meal, when the contents of the stomach are passing into the duodenum. The fatty acid and the bile assist the natural efforts, and then the assimilation of fat is often materially aided.

Regarding indications to be gained from the appearance of the tongue, the author remarks:

In very acute conditions it may become necessary to give milk and milk gruel already largely digested by the addition of liquor pancreaticus, or these may be given at times with ordinary milk and seltzer water, or lime-water at other times in the day. Such are conditions where there is much gastric irritability with vomiting, and a tongue denuded of epithelium or seen to be covered by a growth of young epithelium. This condition is not uncommon in the course of phthisis, and when it shows itself it requires its own peculiar treatment, all others being abandoned for the time at least. Here the line to be taken is that of alkalies and bismuth with or without some hydrocyanic acid. Whenever the tongue is raw or bare then alkalies are to be given, and acids carefully eschewed. If the reader has doubts about the last, let him just try the experiment with his eyes open, and watch it. It will not be long before the results will be apparent to him. Bismuth with soda in calumba is the old

and well-known combination for such state, and with it the milk dietary just described may be combined. More commonly, however, a less grave and acute condition is found where the state of the tongue is just the opposite, namely, covered with a layer of dead epithelium. Here acids are not only unobjectionable, but are very useful. Indeed, soda sulphate with some acid is the combination which gives the most satisfactory results. Under this the tongue soon cleans, the appetite returns, and the stools are of normal color. When the primæ viæ are once more acting normally and in a healthy state, then, and not till then, may some chalybeate be given. But as long as the liver is in any way disturbed chalybeates are useless, and usually disagree. When the appropriate time comes, then iron is useful, but however impatiently the time is awaited it is well to be patient. To resort to iron prematurely is a very common mistake. Sometimes when the tongue is placed in a side light a yellow shade can be detected, and so long as that remains so long must chalybeates be withheld.

Among hepatic stimulants he places more dependence on ipecac than on mercury, arsenic, euonymin, baptisin, iridin, leptandrin, or any other of the so-called cholagogues. Of this he says:

A century of experience tells of the utility of ipecacuanha in indigestion. It was a constituent of the dinner pill of the last century. Not only does it stimulate the liver, and so be useful in cases of indigestion where there is either bile acids formed in excess or lithates present (that is, the peptones which find their way into the portal vein from the intestinal canal, and which, converted into proteids, are elaborated into the albumen of the liquor sanguinis by the liver normally, are transformed instead

into bile acids or urates; the patient loses flesh, and on a flesh dietary only makes more bile or more lithates without gaining weight), but ipecacuanha is a "pepsin persuader" from its action on the gastric lining membrane with its multitudinous glands and follicles. Ipecacuanha combines properties, indeed, as does no other agent, in my opinion. Then there is often atony, either general or in the bowel, and for this strychnia is an admirable remedy. Perhaps, too, flatulence, for which a carminative is indicated. Then there is the vehicle, which may or may not be a laxative, according to the case. The pill would stand then somewhat as follows:  $\mathcal{R}$ . Strychniæ, gr. 1-20; pulv. ipecacuanha, gr. 2-3; pul. piper. nig., gr. iss.; ext. gentian, gr. 1.

#### Intra-venous Injection of Bilin as a Remedy for Cholera.

HENRY CUMBERLAND TAYLOR, L.R.C.P., M.R.C.S., Jersey, England (*British Medical Journal*), proposes, from theoretical considerations, the intra-venous injection of bilin as a remedy for cholera. He reasons as follows: Post-mortem examinations show the liver and gall-bladder distended with bile—a condition which may be explained from the inflammatory state of the intestinal mucous membrane that both prevents the bile from entering the intestine and renders impossible any absorption of bilin from the intestine, even were bile to make its way from the gall-bladder into the bowel. This state of things therefore operates practically to lock up all the biliary elements of the entire body in the liver and gall-bladder, accounting for the engorgement of these viscera as seen post-mortem; for the absence of bile from the vomit and stools during life and from the intestine as seen after death; for the decomposition of the

contents of the intestines; and probably for the thick, clotty condition of the blood before and after death. The obvious theoretical indication for treatment is to restore bile to the blood. But it would be useless to give bile by the mouth or rectum, for the intestine could not absorb it. Moreover, bile itself injected into a systemic vessel causes immediate death. However, bilin, the substance returned from the intestine into the blood by the natural processes, could probably be injected into the veins without danger, except from the introduction of air. Bilin may be prepared from ox-bile, thus: Add ether to extract the fatty matter; separate the latter by decantation; treat the residue with acetate of lead, which will form the tauro-cholate of lead; separate by filtration; suspend the precipitate in water and pass through it sulphuretted-hydrogen gas, which will form a precipitate of sulphide of lead, and leave the bilin (tauro-cholic acid) in solution; separate by filtration; to the bilin, in solution, add carbonate of sodium, which will form tauro-cholate of sodium, the best preparation for injection. This salt should be purified by crystallization. The proper amount to be injected in twenty-four hours is one hundred grammes [28 drachms], this corresponding to the quantity of bile secreted by the liver in the same time. The hundred grammes of tauro-cholate of sodium should be dissolved in one litre [2.1 pints] of water at the temperature of the body. Dr. Taylor submits that the form of treatment here proposed could not be less successful than the various plans which have been followed hitherto and with such eminently unsatisfactory results.—*N. Y. Med. Jour.*

**Rectal Administration of Salines.**

The following is the plan pursued by Dr. W. JAWORSKI in the treatment of disorders of the large intestine (*Memorabilien*): In cases in which there is irregular action of the bowels (constipation alternating with diarrhœa, or either of these conditions alone), when palpitation reveals the presence of impacted fecal matters and points of tenderness in the large intestine, and when the stools are mixed with mucus, he uses injections of a two and a half per cent. solution of soda, of increasing temperature. An ounce and a half of ordinary crystallized soda is dissolved in three pints of warm rain water, and as much of this as possible is injected into the rectum, and retained by the patient for about five minutes. This is done every day, at least five injections being practised. They have the effect of cleaning the bowels of the masses of mucus. Then at least five more injections are given of the same solution, with the addition of a tablespoonful of common salt. These are given only every second day. After the rectum has been well cleaned, and little or no mucus is seen in the stools, the author uses enemata of warmed Karlsbad water—to every bottle of water in cases of obstinate constipation, a tablespoonful of sulphate of soda is added. It is advisable during the treatment by enemata to intermit for several days at a time in order to ascertain what progress has been made. Where there is atony of the rectum it is well to give injections of pure cold water, with or without the addition of common salt, and these are recommended also in the after-treatment. The diet should consist chiefly of meat and milk. In cases of habitual constipation, without catarrh or any apparent lesion of the large in-

testine, the author begins at once with enemata of sulphate of soda. The first injections are warmed, and contain about two tablespoonfuls of Glauber's salt in three ounces of water. Instead of pure water, the salts may be dissolved in Karlsbad water with advantage. Each day the water is used colder, and chloride of sodium is usually added to it. A mixed diet (excluding starchy food) is ordered. When a clearing out of the entire intestinal tract is sought, a glass or two of cold soda-water, with a little sour wine, is ordered. In feverish conditions, or when the stools contain streaks of blood, very cold solutions of Glauber's salt and chloride of sodium are advised. The advantages of the rectal administration of the salines are summed by Dr. Jaworski as follows: 1. The patient is spared the disagreeable taste and the nausea so often following the taking of salines. 2. Such a strict regulation of the diet is unnecessary, and the salts may be given even after a full meal. 3. The entire intestinal tract is not uselessly irritated, but the remedy is locally applied, and acts for the most part only on the diseased portion. 4. The dose can be more easily regulated, for when salines are given by the mouth, the amount that reaches the rectum or acts upon it in any way is a very uncertain quantity. 5. The local effects of heat or cold may be obtained, together with those of the medicines employed, when they are given by enema.

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**Flatulent Dyspepsia.**

The sulpho-carbolate of sodium, in thirty-grain doses given after meals, is recommended in flatulent dyspepsia. Also in ten-grain doses for nausea and vomiting, particularly in pregnancy.

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CONSTITUTIONAL DISEASES.

The Rational Treatment of Typhoid Fever.

Dr. FRANK O. NAGLE in a didactic lecture published in *Med. and Surg. Reporter* thus concludes ;

*Diarrhœa.*—When the bowels are moved but once or twice in the day, no notice need be taken of them. If, however, the stools exceed that number, and are watery, they then tend to increase the exhaustion of the patient, and must be controlled as they may seriously retard the patient's recovery. In the first place, look to the diet. If your patient has been taking beef tea, stop it. Milk and lime-water is the best food under these circumstances. Bismuth S. nitrat. in  $\mathfrak{3j}$ -doses, either alone or combined with one-fourth grain of opium, every two hours, makes a very efficient remedy. If this fails (it rarely does), then a pill composed of plumbi acetat gr. ij. with ext. opii gr.  $\frac{1}{4}$  every three or four hours should be tried.

*Tympanites.*—This is a very constant and one of the earlier symptoms of typhoid fever, and varies very much in severity in different cases. At times it becomes so enormous as to greatly interfere with the movements of the diaphragm and the comfort of the patient. Spirits of turpentine, in from ten to twenty drop doses, in emulsion, every two or three hours, is your principal remedy for the control of this symptom. Turpentine stupes applied to the abdomen, and also in the form of enema may be tried in addition to the internal exhibition of the drug. Opium is also of value.

*Hemorrhage from the Bowels.*—This is more of a complication than a symptom, and is, more or less, significant of danger. Absolute quiet of mind and body should, if possible, be obtained.

Ice and iced water should be freely given. The vegetable and mineral astringents, especially tannic acid and the acetate of lead, are strongly indicated. From five to ten grains of the former, or a three-grain pill of the latter, may be given every two hours. These act locally upon the bleeding ulcers and control the hemorrhage by their styptic action. Opium for this condition is capable of doing much good; first, by allaying nervous excitement, which tends to keep up the hemorrhage; second, arresting peristalsis. Fluid ext. ergot in one-half drachm doses acts through the blood upon the circular fibres of the arterioles, causing them to contract and thereby stopping the hemorrhage. Spirits of turpentine sometimes arrests the hemorrhage when all other remedies have failed.

*Nervous Symptoms.*—Most of the nervous symptoms are an evidence of adynamia, and require the use of stimulants. The principal symptoms are headache, sleeplessness, delirium. For the headache and sleeplessness, the bromides, either alone or combined with chloral hydrat, are strongly indicated. The action of the chloral upon the circulation (heart) should not be overlooked. From 10 to 20 grs. of bromide, with 5 grs. of chloral, with syr. zingiberis, and aq. camphoræ, may be given every two hours until the desired effect is produced. A five-grain Dover's powder three or four times a day is a very efficient remedy to produce a good night's rest. Ice water applied to the head, together with frequent washing of the face with cologne, orange flower or bay water, is very grateful and refreshing, and tends to diminish cerebral vascular excitement.

For delirium, the above measures may be tried and generally with advantage. When stimulants are indicated in the

beginning of the fever, the milder ones, as wine whey, mulled wine, should be employed. Later, as the symptoms become more urgent, the stronger preparations, such as whisky or brandy may be required. These, mixed with milk and eggs, form a highly nutritious but somewhat heavy food, which is adapted to supply the waste consequent upon the rapid tissue changes which take place in this disease, and especially during the acme of the fever.

The indications for the employment of stimulants are: 1. As a rule, in all old persons. 2. All cases characterized by adynamic or ataxic symptoms. 3. Marked typhoid condition; *i. e.*, dry, brown tongue, with sordes on teeth and gums, with excessive tympanites. 4. Persistent headache, tremulousness, and constant delirium. 5. Feeble or absent first sound of the heart, frequent feeble pulse. 6. Complications.

The kind and amount of stimulants to be used are determined by each individual case and the effect to be produced. When there is an improvement in the symptoms for which you gave the stimulus, then it is doing good. When, however, the symptoms are increased, it is then doing harm, and should be diminished or stopped entirely.

*Bath.*—By a bath is understood the taking of a patient whose temperature is over 104° F., and placing him in a bath-tub containing enough water for covering the entire body. The temperature of the water to commence with should be at about 100° F., and afterwards gradually reduced by the addition of cold water or ice if necessary, until you produce a reduction in the patient's temperature. The duration of the bath is determined by each case and the effect produced. The patient is then taken out, rubbed dry, and placed in bed. If the temperature should again

run high the bath may be renewed. In some cases it may be necessary to renew it as often as every two hours, in order to keep the temperature down. To give the bath requires trouble, assistants, and certain appliances. For this reason the bath treatment is not very popular in private practice, and is generally resorted to in hospitals, where they have all the necessary conveniences.

#### Ether in Typhoid Fever.

A French physician considers hypodermic injections of ether very valuable in the adynamic forms of the disease. He reports five cases so treated. Two injections, of twenty drops each time, were made daily, and under its influence the patient was aroused and delirium ceased. In pneumonia, these injections are of the greatest utility, as they are in every malady assuming a typhoid form.—*Med. and Surg. Reporter.*

#### The Malarial Miasm.

The *London Med. Record*, says: As, is well known, malarial fevers are but rarely developed from exposure by day to the air of malarial places, but rather arise from the influence of the night air, especially of those clear nights in which heavy dew is condensed. If the miasm exist, it must be found in the soil and in the dew. Professor SILVESTRINI (*Gazz. Med. Ital. Venete*) collected the dew and soil from notoriously unhealthy places. He first injected the dew hypodermically into two dogs, with no result. He then tried them with an infusion of the soil, filtered and unfiltered, also with no result. As dogs and other animals are not known to suffer from malarial fevers, he determined to experiment on man. He injected the dew under his own skin, having first ascertained that it contained various forms

of bacilli, some sporiferous, some in threes or in fours; no result. He tried the same on his wife with like result. He and his friends made fifty-two experiments on man with the dew and the infusion of the soil, proving that their subcutaneous injection is innocuous. The soil and dew were collected from many places, and used sometimes at once, sometimes after some time. The results support the earlier researches of Professor Silvestrini. He denies that a primitive infection is the cause of malarial fevers.—*Ibid.*

#### **Arsenic as a Prophylactic against Malaria.**

Experiments have been carried out in Italy, under the direction of TOMMASI-CRUDELI, to ascertain the prophylactic value of arsenic against malaria. The results have, says a correspondent of the *British Medical Journal*, been quite favorable. The number of persons placed under arsenic was 455; 401 men and 54 women. Of these, 250 were victims of chronic malarial poisoning, 115 had been recently infected, and 90 were in fair health. There were cured, or, if well, there remained free from attacks, 338; 43 were not benefited; and in 74 the result was doubtful. He particularly notes that of the 90 who never had had any malarial fever, only nineteen per cent. were attacked in this unhealthy year, and those attacked had only slight fevers readily yielding to quinine. The treatment was begun with one lamel containing two milligrammes, about the one thirty-fifth of a grain, of arsenious acid daily. After four days, a second lamel was given; and so on, until four were taken each day. In a few cases, the dose was increased to seven lamels, about one-fifth of a grain, daily, and apparently with better results.—*Med. Record.*

#### **Belladonna in Malignant Malarial Diseases.**

J. W. KENNEDY, M.D., of Louisville, Texas, in the *Southern Practitioner*, says: In our Southern country, where we have so many cases of malignant or pernicious malarial disease, I would like to call the attention of the profession to the use of belladonna or atropia during the stage of congestion. I have used it for two years past with increasing satisfaction. Atropia, hypodermically I deem the best method of administration. I hope those who have not already done so will give it a trial in these trying cases, and report.—*Louisville Med. News.*

#### **Morbid Changes of the Throat, Larynx, and Air-Passages in some Acute Infectious Diseases.**

Dr. E. LOERI, of Buda-Pesth, gives the following as some of the changes which may be observed. In measles, twelve to thirty-six hours before the appearance of the skin rash, there is a diffuse or macular hyperæmia of the mucous membrane of the throat, larynx air-passages, diffuse usually in the mouth, macular on the tonsils and back of the throat. Within twelve hours from the appearance of this hyperæmia there occur small papules, first on the palato-glossal folds. About the time that the skin eruption appears there is profuse catarrh of the pharynx, larynx and trachea, with rapid shedding of the epithelium, and frequent formation of superficial erosions. In the trachea the swelling around these latter may give rise to stenosis. According to the writer, the appearance of such ulcers in the larynx augurs the occurrence of tuberculosis. In scarlatina, the throat is affected twelve to thirty-six hours before the outbreak of the eruption. The writer states that there is often a

sudden disappearance of the affection of the mouth and pharynx coincident with the eruption on the skin coming out. Frequently the eruption in the mouth closely resembles that found with measles. In rubeola there is also hyperæmia, diffuse or spotted, of the larynx and trachea. In smallpox the mouth is affected at the same time as the skin. The pustules are small and imperfectly filled, dry up in two or three days, and in six days are only represented by red spots. Bleeding from them is very common. The writer recommends the use of ice poultices round the neck, ice internally, and such astringents as tannin applied after puncture of the pustules. In chickenpox there occurs either diffuse hyperæmia of the mucous membrane, or a few scattered pustules. In typhus and typhoid, acute catarrh of the pharynx, larynx, and trachea is of frequent occurrence, and often proceeds in the larynx to the formation of ulcers, which have little tendency to heal, and occasionally, about the sixth or eighth week of the disease, cause perichondritis. For this latter condition, "when diagnosed with certainty," the writer recommends tracheotomy as early as possible. In whooping-cough there is usually some catarrh of larynx and trachea, and bleeding from the mucous membrane is frequent. The appearance, during the course of whooping-cough, of ulcers in the larynx, the writer regards as very suspicious of the onset of phthisis.—*Edinburgh Med. Journal.*

#### How to Prepare Water for Drinking.

Dr. J. WALLACE makes the following practically valuable suggestion in the *Lancet*: My plan for years has been to have a tin can large enough to contain all the water usually drunk in a day, filled from the kitchen boiler when the

cooking is in full swing and the water actually boiling. This can is placed beside the filter until the next morning to cool, and then the filter is filled up and the can refilled with boiling water. The filtering completely effects the reëration of the water, and no one would suspect that it had been boiled. Many people would sooner drink pleasant-tasting, though vitiated water, than pure water which had lost its air, and to induce such people to boil water it is necessary to reërate it. Therefore boil first and then filter.—*Med. and Surg. Reporter.*

#### Therapeutic Properties of the Salts of Nickel.

Dr. J. M. DA COSTA has during the past year been giving his attention to nickel and its salts as therapeutic agents. He had prepared for his experiments the chloride, the sulphate, the acetate, the phosphate and the bromide, but has discarded all but the sulphate and the bromide, which he found to be the best preparations. He reports his experiments with these, in the *Medical News*:

As regards the sulphate, the preparation employed was made by digesting nickel filings in dilute sulphuric acid and evaporating. It is of a chrome-green color, very deliquescent, and very soluble in water. He used it in solution, from one to three grains; sometimes in pill; and found it, in the smaller dose, well borne by the stomach. In five grains, in some persons, it occasions giddiness and nausea. In this dose it has no decided effect on the pulse or temperature, perhaps lowering the former somewhat in frequency and slightly reducing the latter. Of its soporific effect he saw no evidence, but has known sulphate of nickel prove something of an anodyne; for in a case of subacute rheumatism at the Pennsylv-

vania Hospital in which it had been stopped, the patient asked to have it prescribed again, as his pains were much relieved while taking it. Of its striking tonic effect, which had been reported, he saw no proof. In night-sweats its action is only very slight. He had some excellent results with it in small, frequently repeated doses, or in doses from one to two grains four times daily, in cases of obstinate diarrhœa. In one such case, a man at the Pennsylvania Hospital affected with trembling associated with beginning sclerosis and valvular disease of the heart, it proved successful, after many remedies had failed. Continuing it subsequently, the heart grew more regular; the nervous phenomena remained the same. In some instances of chronic catarrh of the stomach it has seemed to do much good, but in this respect the chloride answers even better. In the case of a professional man with marked indigestion and some albumen in the urine, in whom iron produced headache and otherwise disagreed, the digestive disorder was speedily influenced, and the albumen disappeared while taking one grain of the chloride three times daily. More than this did not agree. It had also a calming influence on the nervous system. He tried the sulphate in some cases of typhoid fever in which diarrhœa was a prominent symptom. But while not having tested it sufficiently to have formed a positive opinion, its action was far less than had been anticipated.

With reference to the bromide of nickel, which has not been before employed in medicine: The specimens employed were very pure. They were made by digesting nickel filings in bromine and water, and evaporating carefully to crystallization. The salt is green in color, deliquescent, and soluble in water; and in the dose in which it is necessary

to give it, is not offensive to the stomach. While the remedy may be prescribed in the form of pill made with gum tragacanth, it is preferably given in syrup. In using bromide of nickel the effects of the other bromides were produced, but the effect came from very much smaller doses. Thus five grains to seven and a half grains is an average dose; ten, a decided one. And, when this is indicated, it is best to give five grains soon repeated, as less likely to disturb the stomach.

The influence on the nervous system, of the bromide of nickel, is shown by its relieving headache, especially of the congestive form, in its effects on convulsive movements, and its general quieting tendencies. But the main question to be solved was: Does it prove of service in epilepsy? Dr. Da Costa found it act quite as well as any bromide, and, as happens with all, we sometimes by a change to it obtain results which the others no longer yield. He gives a few illustrative cases.

The result shown from a smaller dose than that of the bromides which are generally employed, is a striking feature. Nor can this be accounted for by the bromide of nickel having in its combination a greater percentage of bromine. The combining weight of nickel is higher than that of sodium. Sodium is 23.3; nickel, 29.5; potassium, 39.2. There is, therefore, in the nickel bromide some special action.

Of course, this inquiry suggested a trial, in epilepsy, of some of the other salts, such as the sulphate and chloride, to see if by themselves they had any specific influence similar to the preparations of silver and of zinc; and Dr. Da Costa prescribed these nickel salts to epileptics for some weeks before beginning with the bromide. The result was, the patients had rather fewer attacks.

But while not inert, no striking influence was exerted by the drug; certainly, nothing that compared with the bromide salt.

In conclusion, it seems to Dr. Da Costa that the preparations of nickel, especially the bromide, will be found additions to our therapeutic resources; and are certainly worthy of more careful study than they have hitherto received. —*Med. Age.*

#### Low Temperature in Cachectic Conditions.

Dr. P. LUCAS-CHAMPIONNIERE relates in the *Journal de Médecine et de Chirurgie Pratiques* the case of a child suffering from erysipelas, in which there was not only no fever, but even a notably reduced temperature. The thermometer registered only 91.5° F. He calls attention to the case as illustrating a fact of considerable importance, namely, that in certain cachectic conditions, inflammatory affections which are ordinarily accompanied by considerable fever may run their course without determining any such reaction, or may even provoke a reduced temperature. One should not, therefore, be prevented from making a diagnosis in such a case because of the absence of fever.

#### The Treatment of Diphtheria with Blue-Gum Steam.

Dr. J. MURRAY GIBBES, of New Zealand, advocates strongly (*Lancet*) the treatment of diphtheria by inhalations of steam obtained from the dry leaves of the blue-gum tree (*Eucalyptus globulus*). "Two of my colleagues in New Plymouth have informed me that they lost all their bad cases of diphtheria in the same epidemic that I saved all (save one) of mine; therefore I feel perfectly justified in saying that in *Eucalyptus globulus* we have a cure for diphtheria."

Dr. Gibbes prints notes of the cases of thirty-seven patients treated by him with blue-gum steam, all but one of which recovered. This single death was attributed, not to inefficacy of the mode of treatment, but to inability of the parents to attend to the patient properly. Their eight children all had the disease, six of them being sick at one time. Dr. Gibbes afterward visited France to observe the treatment of diphtheria in the Paris hospitals, and to learn the results obtained. In two wards of the *Hopital des Enfants Malades* devoted specially to diphtheritic patients, despite good attendance, ventilation, etc., the recoveries were but one in five. In six months, of 151 patients on whom tracheotomy had been performed, 42 recovered. The mortality was greatest in cold weather. The windows were kept open, and the temperature (on the day of Dr. Gibbes' visit) was so low as to chill one on entering the wards. The atmosphere was fumigated with a mixture of eucalyptus oil and tar kept hot by means of a lamp. Local applications to the throat were made with "diphtheritic oil," composed of salicylic acid, alum, borax, and eucalyptus oil. The criticism of Dr. Gibbes on this treatment is that the temperature of the wards was much too low, and that the eucalyptus was not so used as to get the benefit of its curative properties. The various preparations of eucalyptus, such as the tincture and the essence, applied with a spray apparatus, would not produce the results obtained by the steam made from the dried leaves and boiling water. The hot steam acts like a poultice. It soothes and allays the inflammation, and promotes the speedy and natural separation of the false membrane, as scabs may be loosened by poulticing. When the membrane is loose it is to be gently removed with a

soft brush, and the part beneath burned at once so that it can not spread the disease. Removal of firmly attached membrane, as is often practiced, wounds the parts and promotes the absorption of the poison by the blood. Occasional inhalations are as useless as occasional and desultory poulticing of any other inflammation would be. There must be an atmosphere of steam which the patient must inhale unintermittingly. "One breath of cold air will undo hours of improvement."

Steam inhalations have long been used in the treatment of diphtheria, but, while any steam would "act as a poultice," Dr. Gibbes maintains that steam impregnated by his method with the medicinal principles of the eucalyptus exerts a special—not to say "specific"—action on the disease. "*Eucalyptus globulus* contains properties which are perfectly antagonistic to the germs of diphtheria." In none of the cases cited did paralysis or other unfavorable sequelæ occur. No stimulants or other internal remedies were required, nor were disinfectants used. The soft brush used to remove the loosened membrane was previously saturated with a weak solution of iron in glycerin, and the denuded surfaces were carefully cauterized. These were the only measures resorted to in addition to the blue-gum steam inhalations. The success of the treatment, Dr. Gibbes states, is largely, if not wholly, a question of attention to minute details.—*N. Y. Med. Jour.*

**Sir Benjamin Brodie's Prescription for Gout.**

℞. Pil. hydrargyri, ext. rhei, ext. coloc. co., āā ʒj; ext. colchici acet., gr. xv. Ft. pil. xv. Sumantur tres horæ somni pro re natâ.

**Hydrobromic Acid as a Substitute for the Bromides.**

Dr. DANA stated at the annual meeting of the American Neurological Association that this acid had been used by the profession chiefly with quinine, under the belief that it prevents or lessens cinchonism. The only extended record of clinical observations regarding this acid that he had been able to find was one by Messini, published two years ago, who used it in thirty-one cases of various kinds, without special benefit. Dr. Dana was led to experiment with the drug, with the hope that it would produce the beneficial effects of the alkaline bromides in epilepsy without causing depression and scurvy. He had now used hydrobromic acid in the treatment of various nervous affections for nearly two years at the Northeastern Dispensary, and he had the clinical notes of over fifty cases of various kinds. The official dilute acid is a ten per cent. solution, of which the dose would be from one drachm to two drachms and a half, well diluted. In *epilepsy* some patients received marked benefit from the use of the acid in doses of four to five drachms a day. Dr. Dana believed, however, that in epilepsy hydrobromic acid could not be used as a substitute for the bromides, except in the non-controllable cases, and yet it undoubtedly has a controlling influence over the disease. In *chorea*, he thought the acid could be used advantageously as a medium for arsenic or strychnine when it is desired to give a sedative. In *alcoholism* it failed in two cases, the patients being on the verge of delirium; and the bromides with chloral were subsequently given, with relief. Hydrobromic acid is a good solvent of quinine, but it *does not prevent cinchonism*, as has been asserted—certainly not, in the small doses usually prescribed.

In most cases of *insomnia* it also acts well. He could say positively that he could give the acid with just as much confidence that it would produce nervous sedation as when the alkaline bromides are prescribed. He had never seen any sign of bromism or any disagreeable constitutional effect other than some drowsiness. He believed that the ordinary custom of prescribing from twenty minims to one drachm of the three per cent. solution, the strength ordinarily employed, or of a ten per cent. solution, was generally much too small a quantity. Theoretically, in order to get the sedative action, from a drachm and a half to two drachms and a half of the ten per cent. solution must be prescribed. Practically he had found that very satisfactory sedative effects could be produced with drachm doses of the officinal dilute solution. In conclusion, the acid could be substituted for the bromides in all the milder affections for which the latter are used. It had appeared to him to be especially efficient in producing vascular and nervous sedation in the post- and prehemiplegic conditions. Unless given in very large doses, it takes several days to get its best sedative effects. Dr. W. A. Hammond stated that he used hydrobromic acid for seven or eight years, and then abandoned it because he did not see that it did any good. He had found, however, that it does prevent the unpleasant effects of sulphate of quinine; but in this respect it is not so efficacious as a corresponding dose of the alkaline bromides. Dr. Hammond's experience concerning the power of this acid to prevent cinchonism was corroborated by Dr. Eskridge, of Philadelphia, who also spoke of the good effects of the drug in typhoid fever. — *Can. Lancet*.

## DISEASES OF THE NERVOUS SYSTEM.

### Sensation and Consciousness not Simultaneous.

In the *Comptes Rendus*, M. BEAUNIS has given an account of his interesting investigations to determine the time between the instant of excitation of a sense, and the instant at which the person indicates by a signal that he has become conscious of the sensation. In the matter of smell, for instance, he gives a table of the numbers obtained with ten substances, these ranging from thirty-seven hundredths of a second for ammonia and forty-six for acetic acid, to sixty-three for mint, and sixty-seven for carbolic acid; in the case of musk, M. Beaunis was unable, notwithstanding repeated attempts to fix precisely the moment of the smell sensation. The numbers obtained are said to show that the reaction time for smell is longer than that for touch, sight and hearing. — *Med. Record*.

### The Treatment of Insomnia.

Dr. THOMAS LEGARÉ, of Charleston, read a paper on this subject before the South Carolina Medical Association at its last meeting (Transactions), which concludes as follows:

1. Retire early to bed; two hours' sound sleep before midnight are of more benefit to the body than double the number of hours in the day.
2. Eat little, and always some hours before going to bed; cold food only should be taken for supper.
3. The cares and burdens of the mind must be put aside; none should be carried to bed with us. Never read or study in bed.
4. Our bed-chamber should contain pure, sound air, and be roomy and high if possible; and the windows should be always kept open, except in the night time.
- 5.

When in bed, endeavor to lie horizontally, with the head slightly raised. If there is any forced or constrained posture, making the body form an angle, circulation in the stomach is checked, and a free and uninterrupted circulation of the blood is defeated. 6. It is improper to have a light burning in the bed-chamber during the night; our senses should not be acted upon by external impressions. 7. Endeavor to sleep not less than six, nor more than eight hours in the twenty-four; and we would endorse the well-known motto,

"To go early to bed and early to rise,  
Will make a man healthy, wealthy, and wise."

#### Veratria in Tremor.

M. FERIS, of Brest, claims that in disseminated sclerosis, alcoholism, and adynamic states, it will be beneficial, and that it will cause various kinds of tremors to disappear in from ten days to two weeks. He uses it in doses of four pills daily, each containing 1-120 of a grain of veratria.—*Ibid.*

#### Serpent Venom as a Remedial Agent in Tetanus.

Dr. A. O. AMEDEN, of Glens Falls, N. Y., has experimented with the venom of a rattlesnake in a case of traumatic tetanus (*Medical News*) with most satisfactory results. Marking the contrast between the appearance of tetanus and that of snake-poisoning; in the one, the extreme rigidity and spasm of nearly the entire voluntary muscular system, and, in the other, a paralysis of both involuntary and voluntary muscles, the poisons were considered so obviously antagonistic that the doctor was induced to try the experiment. Having a case of tetanus in practice, and having obtained venom fresh from the fangs of the rattlesnake with a moistened point

of a hypodermic syringe, the poison was inserted beneath the cuticle in the upper dorsal region near the spine. Symptoms of snake-poisoning rapidly followed, with a decided amelioration of the tetanic spasm and rigidity, which entirely ceased at the end of ten hours, and the patient enjoyed a quiet sleep of six hours' duration. Thirty hours after the insertion of the poison, however, rigidity with slight spasms again came on. A second introduction of the venom was made as before, and no further trouble with tetanus was experienced, and the patient made a fairly rapid recovery. But extreme prostration followed the last introduction of venom, which necessitated alcoholic stimulation. The doctor believes snake-poison can be used with comparative safety, and may yet prove to be a valuable remedial agent in tetanus.—*Md. Med. Jour.*

#### Chloroform Internally Administered.

This anæsthetic has enjoyed some repute of late in France as a remedy for the relief of pain, when internally administered. It is prepared for this purpose in the following way: A flask is about three-fourths filled with distilled water, and an indefinite quantity of chloroform added. It is then thoroughly shaken at frequent intervals for about an hour; and then set aside. When the upper part of the mixture becomes perfectly clear, it is decanted from the cloudy deposit formed by the excess of chloroform at the bottom. This "water of chloroform" is of the strength of about nine parts per thousand. Diluted with an equal amount of distilled water it has a most happy effect in the pain or nausea attending the process of digestion in dilation of the stomach. Dr. de Beurmann recommends it also in pain accompanying organic disease of the

stomach, in nervous vomiting, and in the vomiting of pregnancy. It is of rather agreeable flavor, and may be advantageously employed in combination with orange water as a vehicle for the solution of chloral and other hypnotics, and also of salicylate of soda. At ordinary temperatures it is a stable preparation, and uninfluenced by the action of light.—*La France Medicale—Med. Record.*

#### Recovery from Locomotor Ataxia.

Dr. LOUIS HENRY reported the following case to the Victorian branch of the British Medical Association (*Australasian Med. Gazette*): A man twenty-nine years of age, of temperate habits and free from any suspicion of syphilis, had been suffering for some months from symptoms of progressive locomotor ataxia. The distinctive signs of the disease were well marked and steadily increasing in severity. He was first put upon large doses of iodide of mercury, but as neither the fulgurating pains nor any other symptoms were improved after a two weeks' trial, nitrate of silver, in divided doses of one grain per diem, was substituted. The patient was anesthetized and the whole length of the spinal region was cauterized with the button of the thermo-cautery. The ulcers were kept open by a covering of a strip of linen smeared with resin ointment. The patient was further ordered the use of foot-baths of common salt three times a day; and during his stay in bed was to wear stockings containing powdered mustard. After about three weeks of this treatment, the nitrate of silver being gradually forced to one grain three times a day, the resin ointment was removed and the back allowed to heal. The legs were now massaged twice daily; and a solution of iodide of potassium, eight grains, and

liquid extract of ergot, one-half drachm, ordered to be taken at 8 P. M. and 3 A. M., with the view of allaying the slight pains in the legs and controlling the emissions which rarely but occasionally made their appearance. A very marked improvement now began to show itself. The pains in the lower limbs completely disappeared, the abdominal constriction vanished, the emissions ceased, the walk and gait became more sure and natural, and the patient regained sensation in his feet, so that, with his boots on, he could, when the report was made, feel the divisions in the wooden floor. For the past two weeks he had been taking eight-minim doses of the liquor strychniæ, and faradization was applied to the spine and lower extremities by means of a wire brush. The improvement, which was very evident, would, the author hoped, be permanent.—*Med. Record.*

#### The Tuning-Fork in the Treatment of Neuralgia.

Dr. RASORI uses the tuning-fork in the treatment of neuralgic pains, applying it, while vibrating, over the course of the painful nerve. The sitting lasts about half an hour, when the patient is usually relieved, without further treatment. He relates the case of a woman who had suffered from vomiting during the neuralgic attacks, but after the relief obtained by the application of the tuning-fork she was troubled no more in this way (*Cincinnati Lancet and Clinic*). The principle of this treatment is the same as that employed by Dr. Mortimer Granville. He uses an instrument recently described in these columns, called the percuteur, by means of which he is able to make a number of taps in regular and rapid succession, and of varying intensity to any part of the surface of the body.—*Ibid.*

**Neuralgia of the Head.**

Dr. J. W. M. CZARTORYSKI: Moisten cotton well, and introduce into the previously cleaned ear of the patient, with the following lotion: R. Ext. belladonnæ, fl.; ext. viburnum op. fl.; ext. gelsem. semp. Equal parts. M. The local action on dental branches of quintus trigemini are marvelous. It will relieve in the same way, even toothaches in the worst form in less than five minutes.—*Med. Brief.*

**Hysterical Trance.**

Dr. ROSENTHAL reports an interesting case of hysterical trance in which a country practitioner declared death to have ensued. A looking-glass held to the mouth did not show any moisture, and melted sealing-wax dropped on the skin caused no reflex movements. Rosenthal, who was accidentally present, found the skin pale and cold, the pupils contracted and insensible to light, the upper and lower extremities relaxed, the heart's impulse and the radial pulse imperceptible. Auscultation, however, showed a feeble, dull and intermittent sound in the cardiac region. No respiratory murmurs were audible. All the muscles of the face and extremities responded well to the faradic current. Although the patient had been apparently dead for thirty-two hours, he thereupon informed his relations that it was only a trance; and recommended that attempts at resuscitation should be perseveringly followed. On the following day he received a telegram to say that the patient awoke spontaneously twelve hours afterward, and gradually recovered her speech and movements. Four months afterward the patient called upon him, and informed him that she knew nothing of the commencement of her attack of

lethargy; that she had afterward heard the people about her talk of her, but had been utterly unable to give the slightest sign of life. Two years afterward she was still alive and tolerably well. Rosenthal appropriately likens this condition to that of "nightmare," where, in spite of distressing sensations, the dreamer is unable to call for help or to make any movement which might save him from some imaginary impending danger.—*Med. Record.*—*Louis. Med. News.*

**DISEASES OF RESPIRATORY ORGANS.**

**The Renal Asthma**

That appears sometimes comparatively early in Bright's disease, Dr. MILES has frequently observed to consist in the alteration of the ordinary respiratory rhythm by the introduction of active or forced expiration, giving the panting respiration of mental agitation (*Md. Med. Jour.*) The patient's speech is interfered with, because the respiratory act is precipitate and beyond its control. There is an abnormal excitement of the respiratory centres. This is sometimes accompanied with a feeling of anxiety and apprehension; sometimes not. It may come on in a moment and last but a short time, and be so little marked that the patient does not seem aware that he is breathing abnormally.—*Ibid.*

**Pulmonary Congestion of Rheumatic Origin.**

In the medical section of the Association Française pour l'Avancement des Sciences, Dr. HUCHARD presented an interesting paper on this subject. Congestion of the lungs may occur during an attack of acute articular rheumatism; and may be generalized, in which case

it is often most alarming in its severity, or local, when it is usually unattended with danger. Or, perhaps more frequently, it comes on without any articular symptoms in rheumatic subjects. There are two forms under which the congestion presents itself. In the first, it is acute and may be shifting. This variety may often be accompanied by profuse hemoptysis, preceded by symptoms of pulmonary congestion. But the hyperæmia may not go so far as hemorrhage, and then there are symptoms only of great oppression. Sub-crepitant râles are audible, together with blowing respiration. There is dulness on percussion, and absence of vocal fremitus. Such a state is sometimes incorrectly diagnosed as pleurisy. The second form is stationary and chronic. The congestion may persist for years, finally disappearing entirely upon the advent of articular symptoms. Such cases are very liable to be mistaken for tuberculosis. The hemoptysis, the author thinks, is due to the giving way of portions of the vascular walls in which pathological changes of rheumatic nature have taken place. It is analagous to the rupture of the cerebral vessels in apoplexy. Arthritic hemoptysis, while of much less gravity than that occurring in pulmonary tuberculosis, yet calls for systematic and persevering therapeutic management. M. Huchard recommends the prolonged use of quinine, salicylate of soda in small doses. The arsenical preparations, or the iodide of potassium and of sodium, also in small doses. He also uses intestinal derivatives, such as aloes, leeches to the anus, dry cups, or even phlebotomy.—*La Tribune Médicale—Med. Record.*

#### The Treatment of Acute Bronchitis.

With the view of promoting the free secretion from the bronchial mucous

membrane, Dr. MAIN (*Glasgow Med. Jour.*) has found nothing more useful, both for adults and children, than the following: *R.* Potass. bicarb., 3 iij.; tr. hyoscy., 3 iij.—3 iv.; spt. æth. nitrosi, 3 ss.; spt. chlorof., 3 ij.—3 iij.; aq. ad. 3 xij. *M.* And *R.* Acidi citrici, 3 ij.—3 iij.; aq. ad. 3 vj. *M.* Sig. Two tablespoonfuls of the former mixture to be taken with one of the latter during effervescence every three or four hours (for an adult). If the secretion be profuse and the heart's action weak, he has often found the following mixture useful: *R.* Acidi nitrici dil., 3 ij.; tr. bellad., 3 ij.; spt. chloroformi, 3 ij.; aq. ad. 3 xi. *M.* Sig. Two tablespoonfuls every four hours (for an adult). "In dealing with children, it is well to bear in mind that, if the amount of secretion be excessive and embarrasses the breathing, a timely stimulating emetic, such as carbonate of ammonia, or mustard, often proves invaluable. This now brings us to the stage approaching convalescence, in which such drugs as quinine, vegetable bitters, steel, nux vomica, and the dilute mineral acids all have their uses; and when convalescence has become established, I am of opinion that if we can get our patient persuaded to take cod-liver oil for a month or two, it has the effect of preventing a fresh attack.—*Med. & Surg. Reporter.*

#### Nasal Catarrh.

Dr. A. B. THRASHER (*Cincin. Lancet and Clinic*): The medicinal treatment is of two kinds, viz., constitutional and local. As long as the general health is bad, little can be accomplished by local treatment. The *primæ viæ* must be carefully regulated; this will necessitate attention to the diet. If a constitutional disease be present, then treatment should be instituted accordingly. There

is no specific yet known for catarrh. The remedies given must be governed by the condition of the patient. Whatever course of treatment will tend to put the patient into the very best state of health—this, in brief, is the course to pursue. But with all this—even though carried out with the clearest judgment and in the minutest detail, the patient will usually not recover. Local treatment must be instituted, in addition to constitutional.

Under this head the first condition to be brought about is cleanliness. The cavity, together with all of its ramifications, must be thoroughly cleansed. Possibly the patient may be so instructed as to be able to accomplish this himself. More likely he will not, in which case it becomes the physician's duty.

Various ways have been suggested to accomplish this end. In the first place it must be done gently so as to produce no sensation of pain. There must be no rough tearing away of the adherent crusts or swabbing off of the catarrhal secretion. The Schneiderian membrane is sensitive, and will resent any such treatment, by additional inflammation. Then the cleansing must be thorough, so as to entirely free the surface of the mucous membrane from all secretions. Unless this is done, the local applications will be lost in the overlying secretion rather than reach the inflamed membrane.

Snuffing up a solution of common salt in water is a practice very much in vogue. In this way, when no obstructions exist, the anterior portions of the nasal cavity can be pretty well cleansed. But the posterior portion and, especially, the nasopharynx, is not at all reached. The nasal douche has been held in high favor for the double purpose of cleansing and medicating the nasal cavity.

For general use, the douche has fallen into disrepute on account of the liability of forcing the fluid through the Eustachian tubes to the middle ear, and thus running the risk of otitis media. The douche should certainly never be given to patients to use indiscriminately. Its only legitimate use is under the observation of the physician at his office. Dr. Frank Woodbury, of Philadelphia, has devised a simple yet effective method of administering the douche, which consists of a glass tube bent so as to act as a siphon; a rubber connecting tube, and a nose piece.

Different kinds of syringes have been used, with a straight nozzle for the anterior nares and a curved nozzle to pass behind the velum into the naso-pharynx. These methods may sometimes be useful.

The method, however, which unites more perfectly than any other the two ends sought in cleansing the nasopharyngeal cavity, viz: thoroughness and gentleness, is a coarse spray thrown with more or less force against the adherent secretions. The atomizing tubes should be so constructed as to direct the spray towards the different parts of the cavity.

A rubber hand-ball apparatus, or, better, a cylinder of condensed air may be used to generate the spray. The atomizing tubes should not be too fine, or the spray will not have force enough to remove the inspissated secretion.

Whatever method is used, the fluid should be slightly alkaline and of a specific gravity near that of the intervascular fluids, so as to prevent the too free osmosis. If this point is not kept in view, frequent washings will be of more harm to the parts than the removal of the secretions will do good. Dobell's formula is a favorite one, which I here

give:  $\mathcal{R}$ . Acidi carbolici, liq., m. xl.; sodii biboratis; sodii bicarbonatis, aa.  $\mathfrak{z}$  ij.; glycerniæ,  $\mathfrak{z}$  vij.; aquæ,  $\mathfrak{z}$  viij. M. A drop of ol. gaultheria added to the above increases its antimycotic properties and imparts to it a pleasant flavor. The solution should always be warmed to about the temperature of the human body; or in case you use the spray it may be 50 per cent. hotter, as the cold air in the atomizing tube will reduce the temperature.

The parts having been thoroughly cleansed, then the remedies can be directly applied to the affected part. I use medicine in two different ways: in the form of a powder, by means of an insufflator; and in liquid solution, by means of the spray apparatus.

The powder must be finely pulverized, and of a not too irritating quality. When strong astringents are indicated, as in the case of an excessive discharge or an extreme hypertrophy, they may be combined with non-irritants, such as starch, sugar or acacia. In this way may be used argentum nitras, zincum sulphas, plumbum acetat, etc. Acidum tannicum, bismuthum subnitras, hydrargyrum chloridum mite, iodoformum, etc., may be used alone or in combination. Boracic acid, when finely pulverized, or, better still, precipitated, is a very effective powder.

Liquid medicines, in the form of a spray, I find of greatest utility. The menstruum which I generally use is cosmoline, slightly heated. It is not necessary that the medicines are soluble in this, as a mechanical mixture will answer every purpose. A half drachm of the cosmoline is about right for one treatment. When there is not much hypertrophy,  $\frac{1}{4}$  to 1 m. of fl. ext. pinus canadensis dissolved in glycerine with perhaps half the quantity of carbolic acid has in my hands answered an ex-

cellent purpose. Glycerite of tannin, iodine, carbolic acid in glycerine, and a number of other remedies adapted to the pathological conditions may be thus used.

### DIGESTIVE TRACT.

#### M. Pasteur on the Etiology of Cholera.

The Paris correspondent of the *Lancet* says:

M. PASTEUR having been solicited to lay before the public the instructions he had given the members of the scientific mission to Egypt to investigate the nature of cholera, now raging in that country, and which was noticed in your annotation of last week, has generously complied with the expressed desire of his friends. M. Pasteur prefaced his instructions (of which I send you an abstract copy) by remarking that the precautions hereinafter enumerated relate to those cases where the causes of contagion will be found to prevail in their maximum intensity. These precautions, he added, are instituted under the hypothesis, which he considers very probable, if not certain, that cholera does not enter the human organism by the air passages, but that it does enter by the digestive canal, unless under very unusual circumstances.

1. Not to make use of the drinking-water of the locality in which the mission will be located without having previously boiled the water, and shaken it well, after it has become cold, for two or three minutes, in a bottle half filled; or the water may be put into vessels previously heated, "vases flambé"—that is to say, vessels that had been subjected to air heated to about 150° C., or even more; the higher the temperature, the better. The natural mineral waters may be employed with advantage, instead.

2. Make use of wine that has been heated in bottles to from 55° to 60° C., and which should be drunk in glasses also previously heated.

3. To make use of alimentary substances only after being well cooked, and fruits in their natural state, but previously washed with water that has been boiled, and preserved in the same vessel in which it was boiled, or had been transferred into those previously heated.

4. To make use of bread cut up into thin slices and submitted to a temperature of about 150° C., during twenty minutes or more.

5. All the vessels employed for alimentary purposes should also be previously subjected to a temperature of 150° C., or more.

6. The bed linen and towels should be plunged into boiling water, and then dried.

7. The water for washing or bathing should be previously boiled, and, after being cooled, mixed with solutions of thymic or of carbolic acid, the former in the proportion of 1 to 500 parts, and the latter 1 to 50 parts.

8. The hands and face should be washed frequently during the day with boiled water, and to which should be added solutions of thymic and carbolic acid.

9. It is only in cases where the bodies of patients who have died from cholera or their soiled linen has to be handled that it would be necessary to cover the mouth and nostrils with a small mask formed of two pieces of thin plates of metal, enclosing between them a little cotton-wool of not more than 1 centimetre thick, the mask having been submitted to 150° C. only, and renewing the temperature of 150° on each fresh exposure to contagion.—*Med. & Surg. Reporter.*

#### Calabar Bean in Diarrhœa.

Dr. MASCHKA, of Carlsbad (*Berliner Klin. Wochsch.*), has found this extract of great service in intestinal catarrh, diarrhœa, atony of the alimentary canal, etc., and explains his views of its mode of action. The physiological action of the Calabar bean, Dr. Maschka states, is upon the muscular coat of the intestines, producing contraction thereof. In acute catarrh of the intestines, it controls the hyperæmia of the mucous membrane, and arrests the excessive secretion. Under its continued use, the calibre of the intestine becomes narrow, while its contents are held back or only partially expelled. In cases of habitual atony of the muscular coat, it produces a normal evacuation of the contents of the bowels. Dr. Maschka gives it the preference over preparations of opium, as its continued use does not produce the injurious effects of the latter. Although the author has not much experience of the use of this drug with children, he argues *à priori* that it has a great advantage over opium in their case, as being free from the dangers that attend the administration of opium to children.—*Ibid.*

#### An Anti-Cholera Pill.

Dr. FONQUET, of Cairo, asserts that the following prescription is efficacious as a prophylactic against cholera: R. Asafœtid.; opii; camphor; papav. niger, āā .06 gramme. M. Ft. one pill.

#### The Prevention of Sea-Sickness.

In a communication addressed to the *British Medical Journal*, Dr. J. HENRY BENNET claims to have discovered a preventive remedy for sea-sickness, in the ingestion of strong coffee. He says that some years ago, while traveling

from Paris to London, having some time to spare before the sailing of the steamer, he entered a restaurant and drank two cups of *café noir*. To his astonishment he was not ill at all during an unusually rough passage of the Channel, and he was induced to refer his immunity to the action of the coffee. Subsequent experience confirmed this belief. In order to obtain the desired effect, the coffee should be taken long enough before starting to allow of its absorption. Dr. Bennet has always found this simple remedy of great value in short voyages, but he is unable to say whether its influence would continue for a greater length of time than a few hours.—*Med. Record*.

#### Phosphate of Codeia.

Dr. FRONMÜLLER employs the phosphate of codeia for hypodermic injection. He says that it possesses the advantage over the muriate and sulphate of being much more soluble (*Memorabilien*). The substance crystallizes in slender four-sided columns, is white in color, and of a bitterish taste, and is soluble in four parts of water. Its action is very like that of morphia, but it is milder, and the symptoms of poisoning (such as great weakness, intense headache, bilious vomiting, etc.) are much less often encountered. It seldom causes local irritation when subcutaneously injected. The dose should be at least double that of morphia. The phosphate of codeia is especially recommended in the case of women and children.—*Ibid*.

#### Habitual Constipation.

In the *Brit. Med. Jour.*, Dr. T. ROWING FENDICK says: Looking at it that, as a rule, constipation is due to want of tone in the muscular coat of the bowel,

and to diminish glandular secretion, I usually prescribe a pill composed as follows:  $\mathcal{R}$ . Ext. aloes soc. aquos, gr. ij.; ext. nucis vomicæ, gr. ss.; ipecac. pulv., gr. ss. M. Ft. pil. To be taken each day with dinner. Strict orders must be given to the patient never to neglect going to stool at a fixed hour daily. This prescription usually answers within a month. Another remedy not quite so nice, but nearly as efficacious, is a drachm of castor oil, the first thing each morning, persisted in for some weeks. Should these remedies fail, a small enema, of about half a pint of thin gruel, used every morning, will often overcome the difficulty; but there must be the attempt at defecation made every day. By this practice, the bowel at last, so to speak, recognizes the necessity of waking up from its torpor; and, aided by the medicines, regains its lost tone.—*Med. and Surg. Reporter*.

#### For Torpid Liver.

The following is suggested by Professor DELAFIELD, of New York:

$\mathcal{R}$ . Podophyllin., gr. 2; hydrarg. bichlorid., gr. 1; pulv. ipecac., gr. 4; ext. colocynth co., gr. 10. M. Ft. pil. No. 20.

I would give him a pill composed of these ingredients in the above proportions, and let him begin by taking three such pills each day. He may then gradually lessen the number as his symptoms improve.—*Medical Gazette*.

#### Impacted Fæces.

The following is highly recommended for the relief of this condition:  $\mathcal{R}$ . Ol. racini,  $\mathfrak{z}$  ij.; ol. terebinth.,  $\mathfrak{z}$  i.; aquæ, o.i.; saponis, q. s., to make an emulsion. Sig.: Use as an enema.

THE AMERICAN MEDICAL DIGEST.

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PART II.

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SURGERY.



# SURGERY.

## FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

### Amputation at the Knee-Joint.

Dr. J. S. WIGHT (Proceedings of Med. Soc. of County of Kings):—The operation which I have performed at the knee-joint may be described as follows :

*First.*—There are three important land-marks to be noted : (1) *The head of the fibula*; (2) *The inner tuberosity of the tibia*; (3) *The patella*:—*The head of the fibula is the leading land-mark.*

*Second.*—The knee-joint may be found by flexing the leg so as to meet the thigh at a right angle. The surface of the upper end of the tibia will be under the posterior surfaces of the condyles of the femur, and at a distance from the front of the femur equal to the antero-posterior diameter of the femoral condyles will be found the knee-joint; or, when the leg is fully extended, the most distal point of the patella will not be far from the knee-joint.

*Third.*—The head of the fibula is generally about one inch below the knee-joint. The apex of the patella does not always, however, mark the position of the knee-joint. But the head of the fibula has a constant relation to the upper end of the tibia, while the patella has a variable relation to the upper end of the tibia as the leg is flexed and extended.

The following points of my operation may now be noted, namely:

1. Find the position of the knee-joint, by observing the position of the apex of the patella, when the leg is extended, and by observing the upper end of the

tibia, when the leg is semi-flexed. The surgeon can be quite sure of finding the knee-joint by observing these two points.

2. Find the head of the fibula, which will in general be easily felt about one inch below the knee-joint. The initial incision should always begin on the top of the head of the fibula and extend directly downward on the fibula about three or four inches, and should be made down to the bone. In this way the inferior external articular artery will not be cut.

3. A second incision should now be made on the inner side of the leg, directly opposite the head of the fibula, beginning over the posterior part of the tuberosity of the tibia, and extending directly downward along the posterior border of the tibia, so that the knife will move mostly back of the bone, a distance of three or four inches. The inferior internal articular artery may or may not be cut.

4. A third incision, nearly transverse, but having a slight convexity downward, must now be made, across the anterior aspect of the leg, from the second to the first incision, nearly three inches below the knee-joint—*down to the bone.*

5. These three incisions mark out the anterior flap—which must contain the soft parts down to the periosteum. To dissect up all the tissues of the anterior flap down to the periosteum all the way up to the knee-joint is an important part of the operation. In making the anterior flap the anterior tibial recurrent artery will soon be cut, and will by its anastomoses aid in supplying blood to the tissues composing this flap.

6. The tendo-patellæ must be cut through, directly over the joint, leaving the patella in the upper part of the anterior flap. In case of disease making it difficult to find the knee-joint, place the edge of the knife across the joint as nearly as possible, and rock the blade up and down, at the same time pressing backward, and when the knife is in the right place it will cut into the joint.

7. (1) The soft parts must now be dissected up from the bone and the external lateral ligaments to the knee-joint, where these ligaments must be cut through into the joint.

(2) The soft parts must then be dissected up from the bone and the internal lateral ligament to the knee-joint, where this ligament must be cut through into the joint.

(3) It is not always easy to raise up the soft parts on the sides of the joint; but with care during flexion of the leg, this step in the operation can generally be accomplished without much delay.

(4) The inter-articular cartilages must, in the next place, be divided, whilst the leg is being flexed more and more toward a right angle with the thigh, leaving the semi-lunar cartilages attached to the upper end of the tibia. During this step of the operation care must be taken to avoid cutting the cartilage on the femoral condyles, although I have never seen any harm come, when thin slices of this cartilage have been cut off by the amputating knife as it finds its way through the knee-joint.

8. An amputating knife must now divide the posterior ligament well down, close behind the upper end of the tibia, the blade being placed against the bone, and in the first and second incisions cutting a posterior flap about one inch longer than the anterior flap. When the knife comes out of the tissues, it should be almost directly backward, or

as the limb is placed, directly downward, so that this flap will be nearly quadrangular. Nearly all of the muscular tissue may now be removed from this flap by the amputating knife. If the inferior internal articular artery has not been cut before, it will be liable to be cut in making the posterior flap, but this does not appear to interfere materially with the arterial supply.

9. (1) The artery, which lies near the bone, is now tied. In one instance of high bifurcation I tied the tibial arteries.

(2) The vein, which lies next to the artery, is then tied, to prevent hemorrhage in the first place, and at a later period to prevent absorption of septic material.

(3) The nerve, which lies nearer the surface, is drawn out and cut off, to prevent, as far as possible, an irritable and painful stump. I desire to draw especial attention to the ligation of the vein and the excision of the end of the nerve, because I am confident these are two points of good surgical practice.

10. When the flaps are completed, the base of the anterior will be about one inch wider than the base of the posterior flap, and the points where the first and second incisions began will be drawn up to the distal end of the femur, but the anterior flap will easily and completely cover the femoral condyles, and the patella will fall well into the inter-condyloid groove. The posterior flap will appear to be too long, and the surgeon may be tempted to make it shorter, especially if he has in mind the operation of Carden. Let not this mistake be made, for the soft parts on the posterior aspect of the thigh have a marked tendency to contract, and the line of union of the flaps will finally be on the lower and posterior part of the femoral condyles: Thus, leaving the anterior flap to cover the entire lower—or

distal—surface of the femoral condyles, so that pressure can be made on the end of the stump without making pressure on scar-tissue.

11. Let me go back a little in my description: After the hemorrhage has been arrested, a drainage tube is put between the bases of the flaps against the femoral condyles, so that an end will project from each side. The patella, as before noted, is left in its normal place on the condyloid end of the femur. The first suture should be put through the middle of the ends of the flaps. The flaps may then be brought together from this point in the directions of the outset of the two primary incisions, by means of sutures.

12. The stump is now laid on a bed of oakum. A cover of oakum is laid over the stump. A wide sand-bag of proper weight may be, if required, laid over the thigh, so as to gently restrain the action of the muscles. An opiate will tend to relieve from pain, prevent spasm, and cause sleep and rest.

There are some important points involved in the operation above described that may be considered in the following remarks:

I. Beginning the two primary incisions that are made on the sides of the limb, about an inch below the knee joint, will leave the angles of the flaps near the distal surface of the femoral condyles, when the operation is completed. But when the incisions begin on the femoral condyles, the distal end of the femur will be unnecessarily exposed, and the flaps may be too short, so that the operator may have to cut off the condyles, thus making an amputation of the thigh—whereas it is his intention to operate at the knee-joint. This would certainly be a grave mistake, for every inch that the surgeon takes from the femur adds to the peril of his operation.

II. Beginning the two primary incisions

as low down as the top of the head of the fibula, making the two flaps quite rectangular, and by making the anterior flap as thick as possible, will leave both flaps well supplied with blood-vessels, and the result will be that the flaps will maintain their vitality in the most perfect and desirable manner. In fact, in all the operations at the knee-joint I have performed by the above-described method the flaps have behaved very well.

III. In my cases the anterior flap always has been, and no doubt will be, drawn gently over and make an excellent covering to the femoral condyles, than which there could be no better result. This normal tissue-cover of the stump is admirably adapted to sustain any reasonable pressure that it may receive from an artificial limb.

IV. The posterior flap will in due time contract and draw its line of union with the anterior flap, so as to bring it just behind the femoral condyles. The internal limit of the union between the flaps will be drawn up more than the external limit. This result will be due, in the main, to the adductor muscles of the thigh.

V. In this place attention may be drawn to the fact that it is not always possible beforehand to estimate exactly how far flaps will finally contract. It is better to have flaps a little too long than to have them a little too short; so I advise operators to make them long enough. In my opinion it is a great mistake to make the posterior flap too short, for a painful scar just back of the femoral condyles will give both the patient and surgeon great anxiety and trouble. In fine, let me not condemn other operations at the knee-joint, but let me say a few words in commendation of the operation I have just described. The last operation done

by me at the knee-joint was performed on the 27th day of October, 1882, for compound fracture of the leg, in a young man, and the result has been most satisfactory. Hence I recommend this method of amputating at the knee-joint ; (1) because the operation is safely and readily performed ; (2) because the flaps will not be likely to perish ; (3) because there will be a good tegumentary covering for the condyles of the femur ; (4) because the operation will be apt to conserve the life and comfort of the patient, and (5) because it will make a stump-end suitable for pressure.

#### Recovery from Broken Neck.

A case of fracture from direct violence of the laminae of the fifth and sixth cervical vertebræ, without dislocation, followed by recovery, is reported to the *Lancet* by Mr. C. JORDISON. Paralysis of the left arm, also, though not complete, in the left leg and right arm, appeared at once or very early in the case. The arms were again paralyzed about the fourth week—probably due to the pressure of the callus on the roots of the brachial plexus. There was also marked atrophy of the muscles, especially of the left hand and arm and the pectorals, and intense hyperæsthesia. Complete rest was required for several months, but in the sixteenth week the patient was riding horseback, and by the twenty-fifth had entirely recovered, except slight weakness in the left arm.

#### Turf-Mould as an Antiseptic Dressing.

The London *Medical Record*, in a report on Antiseptic Surgery in Germany, has the following on the use of turf-mould: A laborer one day appeared in Neuber's clinic, who had sustained a complicated fracture of both bones of the forearms eight or ten days previously, whilst working on a moor, the soft

parts being extensively lacerated and the wrist-joint opened. The man at once got a comrade to surround the fracture, as well as the whole forearm, with a thick paste of turf-mould, on which was then laid a sort of rough splint of wood. With this primitive dressing, he came to the clinic ten days afterwards, and, on being questioned, said he was very well otherwise. Numerous washings in a hand-bath at length freed the arm of all the turf, when it was found that the wound was healing beautifully, and had not a sign of suppuration, the surroundings being without any reaction. Some parts of the wound had united by first intention, others were granulating nicely. On the application of a Listerian dressing and fixation in a better position, the fracture and wound healed readily. The idea that in turf-mould another good antiseptic dressing might be found, then struck Neuber, and he accordingly proceeded to have analyses and investigations made, the results of which showed that the dust resulting from the manufacture of sods of turf by the circular saw, as carried on in Schleswig-Holstein, and which is very light in weight, as well as in color, possesses a powerful affinity for ammonia, and bad-smelling materials generally, and takes up nine times its own weight of water. In the infantry barracks at Brunswick such turf-mould is used as a deodorizer in the privies, and renders faecal products absolutely innocuous. A series of experiments on its use in the dressing of wounds having been carefully carried out, the turf-mould is now used in the following manner, which has been very successful: Bags of gauze wrung out in 5 per cent. carbolic solution are prepared of two sizes, 12 and 24 square centimetres respectively. These are filled with turf-mould (or dust), the smaller bag with mould con-

taining  $2\frac{1}{2}$  per cent. of iodoform, which is laid on the wound directly; it has been disinfected with either carbolic solution ( $2\frac{1}{2}$  per cent.), zinc chloride (8 per cent.), or, at most, 3 grammes of iodoform. Over this is laid the larger bag, the mould in which is saturated with 5 per cent. carbolic solution. The whole is kept in place by a gauze bandage. As these exercise a very ennetic pressure upon the wound and its surroundings, it has been found unnecessary to use the elastic compressive bandages hitherto in vogue, unless in the case of wounds near the openings of the body. In Esmarch's clinic, it has never been found necessary to remove this dressing for secondary hemorrhage, even though the bloodless method is often adopted; and it is the rule to apply a permanent compressive dressing before undoing the tubing above the wound, the only other precautions necessary being that the limb should be elevated, and all ligatures applied before closing the opening. In all, there were treated in this manner, from September to the end of November, 1881, fifty-five wounds on fifty-three patients, the list comprising seven resections and osteotomies, seven scrapings out of carious bones and joints, five amputations, twelve extirpations of tumors, six removals of sequestra, five abscesses, thirteen various wounds, amongst which were seven nerve-stretchings and two herniotomies. There was no fatal case, except one after nerve-stretching for tabes dorsalis, said to be due to pyæmia after disease of the prostate and abscess of the bladder; but such a case should hardly have been operated upon. No diseases of wounds were observed. Thirty-one cases were without fever; aseptic fever occurred eleven times; slight inflammatory disturbance only six times; elevation of temperature four times. In fifty

cases the first dressing remained on until the end of the time intended, mostly a fortnight or more; and in only five was it necessary to remove it before that time had elapsed. Turf prepared according to Neuber's directions may be obtained from the Torfbereitung's Fabrik in Ultersen, Schlesweig-Holstein; and the cost of a turf dressing amounts to 1.80 marks, whereas a carbolic acid Listerian dressing costs upwards of 15.08 marks, if we take an amputation of the thigh as a standard, for which, at least, six complete dressings are required at 2.44 marks; hence turf dressings are eight and one-third times as cheap as these.

Summed up, the advantages of turf dressings are these: 1. A given quantity of the mould takes up more fluid than jute, gauze or cotton wool. If it be lightly moistened, its absorbent power is still increased; wounds remain perfectly dry under it. 2. It possesses a great power of absorbing products of decomposition of organic substances, and hence prevents the same from occurring, and acts even in the unprepared form. Further experiments are being made in this direction. 3. The moistened mould is a very soft but still elastic substance, so that it is easily placed in the required position in the bags before applying them to the inequalities of the body. 4. It is the cheapest of known antiseptic dressings, one pennyworth sufficing for a dressing, and will be more so when it is found that the preparation with some antiseptic can be left out. 5. It makes a very suitable pad for all purposes when inclosed in gauze.—*Mich. Med. News.*

#### Interstitial Injections in the Treatment of Epithelioma.

Dr. DUPLONY says that the uncertain results obtained in the treatment of cancer by interstitial injections are due to

a lack of thoroughness on the part of the operator in not extending the area of injections far enough into the sound tissues. It is essential to the success of the treatment by this method to act not only upon the diseased tissues but also upon what the author calls the generative zone. Dr. Duplony employs concentrated acetic acid which he injects not only into the tumor itself, but into the area beneath and surrounding it in such a way as to encircle the neoplasm by a series of injections. After a variable number of injections, according to the size of the tumor, the new growth is exfoliated, leaving a granulating surface, which is tolerably certain to be free from all cancer elements. The injections are extremely painful, but the pain is of short duration. Dr. Duplony has tried this method in two cases with most encouraging results.—*Le Progrès Médical*.—*Med. Record*.

#### Linear Incision in Cancer of the Rectum.

At a recent meeting of the Société de Chirurgie de Paris, Dr. TRÉLAT reported a case of extensive rectal cancer in a man fifty-six years of age, in which marked relief followed linear incision of the rectum. The patient was too weak to permit of an operation for artificial anus, so a longitudinal incision was made with the thermo-cautery through the posterior wall of the rectum. The man's condition improved at once, and his life was prolonged for eight months after the operation. In the discussion which followed this communication, Dr. Verneuil stated that he had practised this operation many times with benefit. Le Dentu related five cases in which he had performed linear incision of the rectum in cancer with immediate relief of the pain and tenesmus. Després was opposed to the practice and preferred gradual dila-

tation.—*Bull. et Mém. de la Soc. de Chirurgie de Paris*.—*Ibid*.

#### Fibroma of Renal Capsule.

Dr. HÜE recently presented to the Société Anatomique, of Paris, a specimen of a tumor discovered post-mortem in the body of a woman who had died of pulmonary disease. Its presence had not been suspected during life. The tumor was ovoid in shape, of the size of a large nut, and was attached to the convex border of the right kidney by a pedicle which allowed considerable motion. On section, its texture was exactly like that of a uterine fibroid, composed of a mass of irregularly woven grayish white fibres. Its tissue was distinct from that of the cortex of the kidney. The capsule of the kidney was closely adherent to the tumor at its junction with the pedicle.—*Le Progrès Médical*.—*Ibid*.

#### VENEREAL DISEASES.

##### The Treatment of Gleet by Electricity.

Dr. WILLIAM R. D. BLACKWOOD (*Med. Times*): The treatment of gleet by electricity is based upon a procedure essentially like that of stricture. The requisites are a galvanic battery of fifteen to twenty cells of any constant form, such as the zinc-carbon, of Grenet or Léclanche type, the Daniel or the Smee, a good Faradic coil, several urethral bougies well insulated to the tip, a rectal electrode, and a sponge-holder. A *water rheostat* is a valuable addition, as by it we can readily intercalate any needed resistance without shock, and nicely graduate the current to its proper strength. The patient is placed in a horizontal position on a lounge or operating-chair, the genital organs, abdomen and thighs exposed, and the galvanic battery placed

to the left of the operator. A moderate-sized bougie is slightly oiled, and passed on into the bladder, if the canal is pervious, or to the stricture if one exists. To the urethral electrode is attached the negative, and to the sponge-holder the positive pole of the battery. The sponge should be well wetted with salt water, and applied over the bladder or on either thigh, it matters little which. The current is now turned on slowly until plainly but painlessly felt by the patient. If no stricture exists, the bougie is slowly withdrawn until it approaches the glans, when it is again pushed towards the bladder. Under this manœuvre, here and there some little uneasiness, or even pain, is elicited, and at such points the inflamed urethra is probably bare of epithelium, and it is there that the pus or mucopurulent discharge is manufactured. The limits of this painful area being determined, the electrical application is confined to that part alone, and the intensity is graduated to an easily bearable point. From fifteen to thirty minutes is an ordinary séance, and this should be repeated daily, or, better still, if circumstances admit, twice daily. Should stricture prevent access to the bladder at once, gentle but firm and continuous pressure is made by the bougie, with as strong a current flowing as the patient can stand, and in a few minutes usually the stricture will yield, even though it be gristly and tortuous. In such cases it will of course be necessary to employ small bougies, on the same principle followed in ordinary management; but, as before stated, I have so far not failed to pass any stricture ultimately, although I did not succeed in several instances at the first sitting, and sometimes not until the third.

Notwithstanding the difficulty of penetrating the constricting band, the gleety discharge has, as a rule, been notably

decreased by the operation in the cases just referred to, and in several tight strictures I have purposely made the electrical applications to the proximal end of the band for a considerable length of time without pushing the electrode beyond it. Despite the fact that the stenosis still existed, the gleet became less in such cases, proving to my mind the value of constant currents on inflamed surfaces, particularly of mucous character. I also believe that most, if not all, of the discharge, in stricture cases originates just in front of the constriction, because I have often had the secretion to cease for a considerable time by treating the gleet without pushing the electrode onward to the bladder. In cases where the gleet is deeply seated, or where we encounter enlarged prostate, the rectal electrode is preferable for the anode to a sponge handle as before described. The instrument should be insulated around the shoulder or part which is grasped by the sphincter ani, as in many persons this part of the bowel is especially sensitive. Before introduction, the electrode should be oiled, and after its insertion the distal end should be directed towards the anterior face of the rectum, for currents being more or less diffused laterally, are not only unpleasant if they traverse the sacral plexus, but the extra strength required, unless the two electrodes are nearly approximated, render the urethral intensity too great for comfort. This may appear a small point; but little niceties tell in electrical applications, and all currents should be not only easily bearable, but without any discomfort, and this rule holds good in all practice, with a very few exceptions. To further this, the rectal electrode should be not the common ball, an inch or more in diameter, as usually found, but a conical rod four inches long, from which the flow escapes

over a large surface. The urethra is not much more sensitive than the rectum, but the reason why currents easily borne by the bowel are painful in the former is because they are concentrated at a small point, and in the operation under consideration a more or less caustic action is induced by strong currents at the cathode, the alkalies being set free at that pole. The moist condition of the urethra favors this action, for, other things being equal, tissues which contain the most water yield more readily to electrolysis than the dryer portions of the body. In conjoined rectal and urethral electrization the sitting need not be so long as in the method first described, because the effect desired is more directly attained. From five to ten minutes will suffice.

After getting rid of all discharge, it is a good plan to employ Faradism for a few times, as it seems to tone up the relaxed mucous membrane. I suppose any mild astringent injection would answer the purpose equally well, but, having in all cases treated solely by galvanism used the induction coil with perfect satisfaction, I have adopted a routine plan thus far. In many old cases, more or less lumbago and ill-determined pain in the region of either kidney is encountered, and nothing drives this away so quickly and permanently as faradism. The usual plan is to apply the positive to the lumbar spine, and make labile application to the whole abdomen, back and sides. Pretty strong currents are used, but the pressure should be light, and undue contraction of the muscles, especially the rectus abdominis, should be avoided.

During the entire treatment no medicine is administered, except, of course, to regulate the bowel if constipation presents; and even then the induced current, with massage of the abdomen,

is better than drugs in those patients who will carefully comply with the instructions necessary for systematic manipulation of the abdominal muscles. Some people are too lazy to use a rapidly-performed sponge-bath of the abdomen and follow it by a few minutes' kneading. They prefer Seidlitz mixture or a mineral water, although permanent good results are attained by the mechanical treatment, and temporary relief only through the ordinary drugging. Diuretics are not necessary in any case, and all injections must be stopped during the electrical treatment. The diet must be carefully regulated, especially with reference to alcoholic stimulants, which are to be rigidly tabooed.

#### Epididymitis.

Dr. HUGO ERICHSEN (*South. Med. Record*): Epididymitis, an inflammation (as its name indicates) of the epididymis generally follows an attack of gonorrhœa. Some have supposed that it travels the track of the vas deferens, but no evidence has been placed on record up to this time to corroborate this theory. The only explanation which we have for its appearance in gonorrhœa or clap, is expressed by the word "sympathy." Undoubtedly it arises sometimes spontaneously, although such an occurrence is rare. The symptoms of epididymitis are those accompanying any inflammation, redness, swelling, heat and pain. As regards treatment, preventive means are first to be considered. Every patient with gonorrhœa should be made to wear a suspensory bandage, which he can, with very little ingenuity, make himself. When the testicle swells, the discharge from the urethra is suddenly checked, or stopped entirely. Some physician, whose illustrious name I have forgotten, acting on the theory that a re-establish-

ment of the discharge from the urethra would do away with the epididymitis, injected strong solutions of nitrate of silver into that channel. That such treatment is useless, if not criminal, I need not say. Either cold or hot water may be used; in the application of this remedy, the physician must be governed by the feelings of his patient. Hot fomentations are also of benefit. Leeches should not be employed. Lisfranc was the first to advocate their use. Authorities on the subject say that they should be applied along the course of the spermatic cord. Nine times out of ten this cannot be done. They are applied where the spermatic cord is supposed to be, and the extravasation of blood into the scrotum, is the result. This is not a pleasant complication, as I have learned from a case, where it took days and days before the extravasated material was removed. Dr. H. G. Piffard introduced the tincture of pulsatilla nigricans for the treatment of epididymitis. It should be given in small doses (1-10 of a minim) and well diluted. When large doses (from 2 to 5 drops) are used, the pain and swelling increase, while the reverse takes place, when small doses are administered. Dr. Z. C. McElroy recommends an injection of 35 minims of a solution of  $\mathcal{R}$ . Morphine sulph., gr. j.; aquæ, 3j. M. and claims that its use gives rest to the patient, and that the testicle becomes reduced in size. Dr. F. J. Bumstead applies the following:  $\mathcal{R}$ . Ext. belladonna, 3ij.; glycerinæ, 3ss.; aquæ, 3j. M. Sedatives are of benefit. The liq. plumbi acetatis gives relief. When fluid forms in the tunica vaginalis, it should be let out, either by making multiple punctures, as recommended by Velpeau, or a few large incisions, as advised by some modern French physician. It is needless to say that the former is to be preferred.

Incision of the body of the testicle was first practiced by J. L. Petit, forgotten, and then revived by Vidal de Cassis. Later on in the disease compressions which was used first by Dr. M. Fricke, of Hamburg, is of great value. Commencing above, the testicle is strapped equally, but firmly, with strips of adhesive plaster of a finger's breadth. The treatment generally followed before in cases of this kind, is to apply tobacco poultice in the acute stage and strap the testicle later on. I have done so in several cases with perfect success. Now to the consequences of the malady. Many a case of sterility is due to an old inflammation of the testicle, the spermatic canals being plugged up by plastic lymph. Varicocele may also result from an epididymitis.

#### The Therapeutic Use of Soft-Soap.

From a large experience with the use of soft-soap, Dr. BEETZ (*Ärztliches Intelligenz Blatt*, 1882) concludes that this agent is of decided value in many cases of sub-cutaneous suppuration, glandular inflammation, and similar affections. A whitlow, if not already too far advanced, yields very promptly to the influence of warm applications of spiritus saponis kalinus. This preparation is a solution of two ounces of green soap in an ounce of alcohol, to which, after filtration, are added two drachms of spirit of lavender. An elegant preparation is obtained by dissolving the soap in eau-de-cologne. But one of the most satisfactory affections to treat is bubo. And since Beetz has introduced this treatment he has never found it necessary to treat bubos otherwise.

For the last nine years his treatment in certain other affections has been as follows :

For chronic glandular indurations or

abscesses in places in which it is difficult to apply dressings, he uses inunction in the evening with green soap, which is washed away the next morning and repeated during three or four days, with a subsequent interval of a day or more, according to the sensitiveness of the skin. For acute glandular inflammation, whitlows and abscesses in easily accessible positions, linen rags are steeped in spirit of soap, applied to the part, and covered with gutta-percha paper. These dressings must be accurately applied if they are to fulfil their object. For example, in inflammation of the inguinal glands, a good result can be expected only if the surgeon himself fixes the dressing with a spica bandage and safety-pins, not leaving it to the skill of the patient himself. There will be, not a tedious suppuration but a very small abscess, with little or no trouble in walking (as there will be no infiltration). A number of other more serious diseases are enumerated in which, it is stated, a similar mode of treatment has been successful. Professor Senator also considers that soft-soap has fallen undeservedly into disuse (*Berl. Klin. Woch.*, No. 38, 1882). He has used inunctions of soft-soap in numerous cases with most distinct benefit, viz., in chronic non-scrofulous glandular swelling, in indolent syphilitic glandular swelling, and in serous exudations, including the exudations in synovial cavities. He cannot come to a definite conclusion as to the *rationale* of its action, whether it is the massage employed, or the irritation produced, or the alkali absorbed. But the fact of the increased absorption under this treatment he considers undoubted. —*Med. Record.*

#### Cardiac Lesions in Gonorrhœal Rheumatism.

Dr. P. LUCAS CHAMPIONNIÈRE, in the *Journal de Médecine*, calls attention to a rare complication in gonorrhœal rheumatism, namely, cardiac lesions. The reason why these are so few, will be found in the facts that in gonorrhœal rheumatism, the attack is sub-acute, and is confined to one or but few articulations. Following M. Potain's example, Dr. Championnière advises the use of salicylate of soda, and states that while it is of less value in the blennorrhagic than in the common form, it is nevertheless decidedly useful.—*Chic. Med. Review.*

#### The Treatment of Urethritis in the Female.

Dr. FISSIAUX relates fifteen cases, in which Dr. Leblond treated blennorrhagic urethritis in the St. Lazare Hospital in the following way: A short stilette is wrapped round with cotton-wool, covered with coal-tar soap; this is passed into the urethra and retained there. It is renewed every other day. During micturition the patient prevents it from falling out by pressing it with her finger. The *rationale* of the treatment is that the tampon separates the folds of the urethra from each other, and thus keeps the whole surface of the mucous membrane at rest and in contact with the medicament.—*Med. Record.*

#### Brain Syphilis.

Dr. BRANDIES presented recently to the New York Society of German Physicians (*New York Medical Journal*), a young man who had contracted a chancre six years previously. He presented undoubted evidences of having had secondary syphilis. About six months since he had an epileptic seizure, and subsequently two more such attacks. The patient complains of deaf-

ness and vertigo. On examination both ears were found affected with otitis media. In walking, a lack of co-ordination of movements was noticeable. Great improvement has taken place under the use of iodide of potassium. The hearing became much better, and the patient could walk for some distance with closed eyes. Dr. Jacoby believed this to be a case of brain syphilis, and he was inclined to locate the lesion in the rhomboid fossa, near the exit of the acoustic nerve.—*Medical and Surgical Reporter*.

#### The Respirator in Syphilis.

Dr. W. S. OLIVER thus writes in the *Lancet*: The treatment of syphilitic ulcers of the tongue, mouth and fauces by respiration of iodine and carbolic acid, etc., has proved so successful in numerous instances which have come under my notice of late, that I am desirous of giving it publicity in your columns. For the past two years this form of syphilis has been peculiarly prevalent in this command, and, as usual, proved so tedious of cure, and so liable to recur under the ordinary treatment, constitutional and local, generally adopted, that I decided this year to test the efficacy of the "respirator," and I was gratified to find that the results, in all instances, were most satisfactory. The period of trial is as yet too brief to furnish reliable evidence of the constitutional and permanent effects of this treatment; but certain it is that locally its action is most prompt and palpable, all ulcers assuming a healthy appearance generally in forty-eight hours, and wholly disappearing in ten or twelve days. Immediate relief is also afforded from any panic or discomfort previously caused by the disease. After free purgation the only treatment needed is the

use of the "respirator" for four hours daily, two morning and evening, after breakfast and tea. The solution I generally use is Coghill's combination of iodine, carbolic acid and creasote, and I prefer oakum as the material for its retention. The form of "respirator" I have adopted is one I have devised myself, and is furnished with a detachable perforated diaphragm, which admits of its being thoroughly cleansed and purified for use in different cases.—*Ibid*.

#### Boro-Glyceride.

Boro-glyceride, which has been so highly lauded in England as an antiseptic, and has been recommended as an application to indolent syphilitic ulcerations, is prepared as follows:

Glycerine is heated to a high temperature, and boracic acid is added as long as it dissolves, the proportion being ninety-two parts of glycerine to sixty-two of boracic acid. When this is allowed to get cold, a white crystalline compound is formed, which disappears on further heating. Water is evolved during the whole of the operation, and at last, when the steam ceases to be given off, the mass sets into a hard, ice-like substance, and is found to have lost in weight exactly fifty-four parts, which corresponds to the weight of three molecules of water.—*Ibid*.

#### DISEASES OF THE SKIN.

##### Oil of Peppermint in Zoster.

Dr. MEREDITH says that he has found the oleum menthæ pip. more effective than any other form of anodyne application he has tried in allaying the neuralgic pains so often piteously complained of in cases of herpes zoster. These distressing pains, worse in elderly people, are complained of often when the erup-

tion has disappeared; but painting the affected parts over with oleum menthae pip. nearly always affords speedy relief. He has painted the oil over the eruption when it was out in a fresh florid condition, and that with great relief to the patient. The value of this application in pains of neuralgic character deserves to be better known than it is.—*London Practitioner*.—*Med. Record*.

#### The Treatment of Ringworm.

A writer in the *British Med. Journal* says: The difficulty experienced in the treatment of ringworm is known to every one who has seen much of this disease. I therefore think your readers will be glad to hear of a remedy which I have recently used with complete success. Struck with the similarity that exists between the disease known in the East Indies as dobzitch and ringworm, and knowing how rapidly the former yields to the application of goa powder, I was induced to try the active principle of this substance, chrysophanic acid, in the proportion of one drachm to one ounce of vaseline. The result has been the rapid destruction of fungus, and consequently a complete cure. Chrysophanic acid has been recommended in the treatment of psoriasis, but I am not aware of it having been used hitherto for ringworm.—*Can. Jour. of Med. Sciences*.

#### Treatment of Ringworm of the Scalp.

Dr. ADLER SMITH recommends oleate of mercury with ung. petrolei (ten per cent.) in chronic cases of tinea of the hairy scalp. This causes less irritation than the ordinary preparation, and children bear it well, although if the cases are under seven years of age it may be found necessary to dilute it further.—*British Medical Journal*.

#### Scurvy in an Infant.

Dr. VERGER related to the Association Française pour l'Avancement des Sciences a rare case of scurvy occurring in a nursing child. The patient, seven months of age, presented a perfect clinical picture of scorbutus in the second stage. The infant was living under the most wretched hygienic conditions. It died after renal and intestinal hemorrhages.—*Le Progrès Médical*.

#### How to Remove Freckles.

Dr. J. V. SHOEMAKER, of Philadelphia, Pa., states that the careful application of a small piece of the ointment of the oleate of copper at night upon retiring will usually remove freckles. The oleate of copper ointment should be prepared by dissolving one drachm of the salt of oleate of copper in sufficient oleo-palmitic acid to make a soft ointment.

#### Eczema of the Genitals.

M. CHERON in the *Review des Mal. des Femmes*, declares the following application to be especially useful in eczema of the genitals: Chlorate of potassium, fifty grammes; Sydenham's laudanum, thirty grammes; aqua fortis, one litre. The parts should be sponged with this lotion, and covered with compresses saturated with it. A rubber cloth should be placed over the dressing. The same writer also advised the use of tincture of iodine and iodide of potassium in equal parts as a lotion in cases of rebellious pruritus.—*Chic. Med. Review*.

#### Acute Circumscribed Œdema of the Skin.

Dr. QUINKE describes (*Monatshefte für praktische Derm.*, No. 5, 1882) under this name, a disease which bears striking resemblance to so-called giant urticaria.

The malady manifests itself by the appearance of œdematous swelling of the skin and subcutaneous cellular tissues in circumscribed spots of from two to ten centimetres in diameter. These tumors show themselves most commonly upon the extremities in the neighborhood of the joints, but may also come upon the body and face, in the latter region more particularly in the lips and eyelids. The swollen portions of skin are not, as a rule, reddened, but are pale, rather translucent in appearance, and not sharply defined. The subjective sensation is that of tension, itching being rarely felt. The mucous membranes of the lips, soft palate, pharynx, and entrance to the larynx may also be invaded by similar swellings, and to such an extent that difficulty in breathing ensues. One case, in which were manifested gastric and intestinal symptoms, suggests that the mucous membranes of these organs may be also affected. In another instance repeated serous effusions into the joints took place. Coming on suddenly, and, as a rule, simultaneously in different regions, these swellings, after an existence of from several hours to a day, disappear with equal abruptness. By reason of the appearance of successive crops of such lesions, the malady, as a whole, may be prolonged for several days or weeks. The general health is generally undisturbed, but in some cases there was indefinite prodromal indisposition, and during the existence of the eruption heaviness of the head, thirst and diminution in the quantity of urine. A rise in the temperature of the body was never observed. Once having been attacked the individual is subject to recurrences of the disease, usually in the same regions of the body, sometimes at regular, sometimes at irregular intervals of time. The affection appears oftener in men than in women. The patients

were, as a rule, healthy in other respects, some of them of nervously irritable temperament. In one instance the malady was inherited by the child of the patient, the disease manifesting itself during the first year of life. This affection is to be classed among the angio-neuroses. Prophylaxis consists in regulation of the general condition, more especially of the digestive functions. Atropine seems to be of some service. In several instances scarification was necessary on account of œdema of the larynx.—*Med. Record.*

#### Bilateral Herpes Zoster.

Dr. ZINSSER reports a case of this affection in the *N. Y. Medical Journal*. Bilateral herpes zoster is very rare. But three cases are reported. The attacks were quite frequent, and were regularly preceded by a peculiar train of symptoms similar to sea-sickness. The patient is otherwise in good health, strong, and by no means hysterical. His disease is probably of central origin.

#### Tincture of Burdock in Psoriasis Inveterata.

Dr. REITER writes to Squibb's *Ephemeris*, giving an account of a cure in his own case of chronic hereditary psoriasis by the use of tincture of burdock (*Rap-pa major*) seed. The maximum dose used was 3 iv. t. i. d., to be kept up for four months if necessary. The doctor had suffered from the disease for many years.

#### DISEASES OF THE EYE AND EAR.

##### A Pupillary Phenomenon Observed in Certain Morbid Conditions in Childhood.

Dr. PARROT records in the *Revue de Médecine* a number of observations made by him in regard to a reflex dila-

tion of the pupil, occurring in certain pathological conditions in young children. In these affections, dependent or not upon evident lesions of the nervous centres, accompanied or not, by convulsions, but always by coma, if the skin of the epigastrium or of any other part of the body be pinched, there follows a momentary dilatation of the pupil. Among the affections in which this phenomenon is observed are tubercular meningitis, hemorrhage beneath the pia mater, some cases of chronic hydrocephalus, and certain other undefined conditions in which the contents of the cranium are increased out of proportion to its capacity. In other comatose conditions, usually without convulsions, there is no response of the pupils to even violent pinching of the integument. In these cases there may be œdema or marked congestion of the pia mater, but the factor of cerebral compression is absent. From his present observations the author is unable to determine the precise diagnostic or prognostic value of this phenomenon, but he formulates one conclusion, viz.: In a child in a comatose condition, whether there be convulsions or not, if the pupils do not respond to peripheral irritation in the manner indicated, we can exclude meningitis and hemorrhage beneath the pia mater—the child is suffering from asphyxia and his death is imminent.—*Med. Record.*

#### A Specific for Ophthalmia.

An infusion of the curious scarlet seeds of the *Abrus precatorius* has long been used in the interior of Brazil as a popular remedy in the treatment of ophthalmic disorders. In some experiments made by Dr. DE WEAVER (*Comptes-Rendus*) to test the action of this remedy, he found that a weak cold infusion, made from the powdered seeds, when applied as a lotion, rapidly produced a

purulent ophthalmia of intensity corresponding to the number of applications made. The factitious ophthalmia thus produced disappeared in the course of ten days or a fortnight without any therapeutic intervention or danger to the cornea, and Dr. De Wecker is of the opinion that this property possessed by the seeds of provoking a very intense ophthalmia of short duration could be utilized in ocular therapeutics in the treatment of granulations, conjunctival diphtheria, etc. The leaves of the plant are also used in the East as a remedy in croupal cough.—*Medical Press.*

#### Congenital Displacement of the Lens.

Dr. F. E. D'OENCH (*Archiv. Ophthalmology*), from a careful study of this subject, concludes: 1. Ectopia of the lens is a malformation, the causes of which, thus far, remain unknown. 2. It always affects both eyes, generally in a symmetrical manner. 3. The direction of the displacement is almost always either upward, upward and inward, or upward and outward. 4. The lenses are generally transparent; sometimes their size is below the mean. 5. The suspensory ligament is sometimes found, sometimes not. 6. In about one-fourth of all cases there is myopia. 7. The position of the lenses may remain unchanged throughout life, but spontaneous discoloration may also result. 8. Heredity has been proven.—*Det. Lancet.*

#### Amyloid Tumors of the Conjunctiva.

In an elaborate article on the clinical significance of so-called amyloid tumors of the conjunctiva, Dr. KUBLI, of Dorpat (*Knapp's Archives*, vol. xi., 1882), states that in the preliminary stages of the affection the conjunctiva is the only tissue attacked. Later on, however, other portions of the lids, or even other

## SURGERY.

ocular tissues, may become involved. In twenty-seven cases (thirty-seven eyes) the whole conjunctiva was affected in thirteen, the conjunctiva fornix in one, the scleral conjunctiva in four, the tarsal conjunctiva in one. The prevalent locality is the upper fold and neighboring portions of the tarsal conjunctiva. He divides the stages of development into four: 1, simple adenoid proliferation of the subconjunctival tissues; 2, hyaline degeneration; 3, exquisite amyloid degeneration; 4, calcification and ossification. If the neoplasm be poorly supplied with vessels, it is generally of a bright yellow color, glassy and elastic; if highly vascular, it varies from reddish yellow to reddish brown. During the first phase of development the most common symptoms are heaviness of the lids and increased sensibility of the eye to various influences. In the second the surface of the tumor becomes smooth and glistening. The greater the vascularity of the tumor the less its consistency. Tumors in this phase are harder than those in the first, and more elastic than those in the third. In the third the consistency varies from hard to gelatinous, depending on the degree of vascularization. The tissues sometimes pit on pressure. In the fourth phase the amyloid degeneration is complicated with the presence of chalk or true bone, sometimes deeply situated in the tumor, and discoverable only by the microscope. The disturbances caused by amyloid tumors are chiefly mechanical, and include deformity, impaired mobility always of the lids, and often of the globe, ptosis and secondary affections of the cornea, pannus and consecutive impairment of vision. The disease has nothing in common with trachoma, but originates in a hitherto healthy conjunctiva. The simultaneous existence of trachoma and amyloid degeneration

must be looked on as accidental. Relapses sometimes occur after extirpation, and the author thinks that they are frequent in proportion to the degree in which true amyloid degeneration has taken place. The treatment, when possible, should be radical extirpation at once, but, if not, then partial extirpation at intervals, in order to prevent symblepharon. The chief point in the after-treatment is to cleanse the conjunctiva sac frequently and thoroughly with a two per cent. solution of boracic acid, which does not irritate.—*N. Y. Med. Journal.*

### Iodoform in Eye Diseases.

LIEBER uses iodoform in vaseline 1 to 10, and finds it very useful in strumous inflammations. In acute inflammations most eyes bear only a very small quantity of iodoform; in other cases it is generally well borne. Iodoform shows its superior action in fresh wounds of the globe of the eye, alike from accident or operation. In scleritis and episcleritis it is of no use; whilst in ulcer corneæ serpens it is almost a specific.

Grossman finds that iodoform is specially useful in the abundant purulent discharge of gonorrhœal ophthalmia, and in ophthalmia neonatorum.

Fischer remarks: 1. That it is well borne by most diseased eyes. 2. It is the most successful remedy in pannus scrofulosis and trachomatosis. 3. As an antiseptic, it is of service in operations. 4. It hastens the formation of healthy granulations, and the regeneration of corneal epithelium. 5. It is of considerable worth in dacryocystitis.—*Wien Med. Woeh.*

### Modification of the Operation of Transplanting the Ciliary Border of the Lid.

PANAS (*Arch. d'Ophtal.*) recommends the following modification of Anagnostaki's operation for the relief of entro-

pium. He dissects up completely the ciliary flap from above downward to the free border, where it is only held by the mucous membrane. He then dissects up and pushes upwards the fibers of the orbicular muscle by means of a blunt hook. He then fixes the ciliary flap to the suspensory ligament of the lid by means of needles armed with a suture. In cases of inveterate trichiasis with involution of the tarsus he adds to this operation a tarsotomy, in which the transverse section is made, of course, before the application of the sutures.—*Ibid.*

#### Glioma of the Retina.

PONCET (*Arch. d'Ophthal*) records some interesting facts in connection with a case of retinal glioma. He thinks it singular that, in a tumor which returns as rapidly as glioma, we so seldom meet with cells with a segmented nucleus or a double nucleolus; and therefore, he thinks that the rapid growth of glioma cannot be attributed to this mode of evolution. In the case seen by Poncet the sclera was healthy, as was also the cornea, but Fontana's space was obliterated and the iris atrophied. The walls of the blood-vessels were the seat of the formation of giant cells. The neoplasm was in the vicinity of the ciliary processes, and in the midst of the hæmorrhagic exudation, in the posterior segment of the eye-ball, were masses of gliomatous cells, irregularly scattered through the vitreous. The ciliary muscle was atrophied, but not gliomatous. In the choroid the internal limitans was intact, the capillary zone was but slightly affected; and the glioma was mainly developed in the deep layers of the choroid nearest the sclera. In the optic nerve the elements primarily the seat of the degeneration were the cells of the neuralgia, and the nerve fibers had become granular by the pressure exercised

by the neoplasm. From the masses of cells in the immediate vicinity of the disc, and the condition of the optic nerve, Poncet regarded it as certain that the disease began in the papilla. In the blood-vessels the first tissue affected was the endothelium, and here the proliferation started. This he regards as a proof of the epithelial nature of glioma. He also thinks that glioma may be propagated as well by the grafting of one cell, or even of the granulations of protoplasm, as by dichotomic division of the nucleus. He found that when the retina remained attached to the choroid, the march of the neoplasm was very rapid, but, when the retina was detached, the progress was less rapid, and the eyeball retained its shape longer. The detachment is a mechanical act; a formation of adhesions by epithelial desquamation, a more or less thick, fibrinous exudation in greater or less abundance, a gliomatous perforation in the choroid so situated as to retain the retina in place, would all hinder the detachment and favor the propagation of the neoplasm; but these are entirely accidental. Whenever this tendency to detachment occurs, the disease is isolated in an exudation for a certain time before it involves the other membranes by grafting or cell migration. If enucleation is done at this period, a return of the disease is certainly postponed, and perhaps prevented.—*Ibid.*

#### Medication of the Middle Ear and the Nasal Mucous Membrane.

M. PURICELLI claims that substances may be brought in contact with the nasal mucous membrane and be retained there by the pronunciation of the vowel A, at the same time throwing back the head, and breathing through the mouth, thus preventing all communication between the nasal fossæ and the pharynx. The liquid will penetrate to the middle ear if R be pronounced while a stream of air is forced through the nose.—*Chic. Med. Rev.*

**FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.****Fracture of Thigh.**

Clinic of JOHN USHURST, M. D.  
(*Med. and Surg. Reporter.*)

This man, beyond middle age, was brought here with a fracture of the shaft of the left thigh bone. On his admission we found the limb to be from three-fourths to one inch shorter than the other, with decided eversion of the knee and foot, and with well marked crepitus. He has been under treatment for ten days and everything has been going on well. There is now less than a half inch shortening, with the bones in good position and the limb quite straight. We have had here but very slight effusion into the knee joint, much less than is usually present in injuries of this kind. Effusion into the joint makes the patella float; by pressure it can be pushed down, but when the pressure is removed it rises. This symptom is almost universally present in fractures of the shaft of the thigh bone. The correct explanation of this symptom has been given by the French surgeon Gosselin. The blood which is poured out in the neighborhood of the fracture gradually finds its way to the outer side of the synovial membrane, causing by irritation a subacute synovitis and consequent effusion into the joint. This effusion usually occurs some hours or even days after the injury, and lasts one or two weeks. It is important that you should know that this effusion is dependent on the fracture of the femur, and is not an evidence of injury of the joint itself, as otherwise, when the knee begins to swell, you may be blamed for having overlooked a lesion which it will be thought you ought to have discovered.

The swelling of the knee is of no con-

sequence, except as influencing the mode of dressing. Some surgeons in applying the extending bands in cases of fractured thigh, carry them up to the seat of fracture and secure the ends by a circular band above the knee; then, if swelling of the knee occurs, some pain is caused. This is one of the reasons why I do not carry the extending bands above the knee. I have no faith in the doctrine that extension thus applied stretches the ligaments of the knee joint. The extending bands pull evenly upon the skin and all the tissues of the limb, and there is no reason why the extension should be specially transmitted to the ligaments.

These cases, as you know, are almost invariably treated by extension; the weight or amount of the extending force varies much in the hands of different surgeons. You will generally find that two or at most three bricks are sufficient; a brick weighs about four and a half pounds, so that from nine to fourteen pounds is about the weight usually required. We should begin by using one brick, causing slight extension, keeping the leg in position and decreasing the tendency to muscular spasm, afterward adding a second brick, and perhaps a third. Some surgeons use very heavy weights, ranging from twenty to thirty or even forty pounds. This I do not think at all necessary, and the use of such powerful extension is liable to cause delayed union, or even non-union. With regard to the occurrence of shortening after fracture of the thigh, I may say that as far as my experience goes, shortening occurs after all fractures in adults. The union or healing of the two ends of a broken bone has been not inaptly compared to the mending of a broken piece of sealing wax; before the broken ends can be united they must be melted, and in the process of melting a

certain amount of length is lost. The extremities of the broken bone are softened in the formation of granulation tissue, which then goes through the different stages of callus, and finally is replaced by new bone. In adults a certain amount of shortening is, I believe, unavoidable, though it may be very slight. In children, instead of a diminution of length we may have even an increase; the transmitted irritation develops to an exceptional degree the bone-producing power of the epiphyseal cartilages, and there is thus a positive hypertrophy as regards length; while, as far as the fracture itself is concerned, there is shortening. This hypertrophy we do not have in adults, as the bones have, in them, already attained their proper growth.

In order to maintain the limb in its proper position, we require to fix the adjacent joints. When a joint is involved, one of the objects of treatment is to fix the bones above and below the articulation. In this case we want to fix both the knee and hip joints, and to accomplish this I like a long splint—either a Liston or Desault splint, with the foot-piece left off. This is then simply a long piece of board extending from the axilla to just below the foot, with another shorter piece reaching from the scrotum to the inner malleolus. These are either padded or simply wrapped in a splint-cloth, long bags filled with bran, called junk-bags, being placed between the splint and the limb. To explain why these bags are called junk-bags, several explanations have been offered; one of them is that the name is derived from the French word "*jonc*," meaning a reed, a rush; the idea being that the early surgeons used in their treatment splints made of reeds; another explanation is that the word "junk" is a corruption of the bags be-

ing used to assist the "junction"—joining of the bones. I prefer the long splint and junk-bags to sand-bags when the fracture involves the shaft of the bone. In these cases there is always a tendency to bowing outward of the limb, to prevent which requires firmer lateral support than can be given by the sand-bags alone. In fractures of the neck of the bone, however, where lateral support is not so necessary, the sand-bags answer every purpose. We need under the tendo-Achillis a little padding to keep the heel off the bed, after which, the junk-bags being pressed in position by the splints, strips of bandage are fastened across to keep these together. We generally use five of these strips: three for the limb—one at the uppermost part of the thigh, one at the knee, and one at the ankle; and two for the body, one around the thorax and the other around the pelvis. We are in this case obliged to dispense with the pelvic band, as the patient has such a huge belly that we cannot adjust it properly. The extension should be so arranged as to keep the limb somewhat abducted from the line of the body.

#### Amputation at the Hip Joint—Prof. Trendelenburg's Method.

In the American *Medical Journal* Dr. VARICK of Jersey City Hospital describes an amputation at the hip joint, which was successful mainly through the saving of blood by using Prof. Trendelenburg's method of preventing hemorrhage. This method requires a flat steel rod a foot long and 1-4 inch wide, with a movable lance-shaped point, the rod to be bi-convex on section, one-fourth of an inch thick in the middle, with blunt but smooth edges. This rod is thrust obliquely through the soft parts in front of the joint, in the same way as the two-edged knife in the

well known method of Lisfranc, but nearly an inch higher. The rod enters  $1\frac{1}{2}$  in. below the anterior superior spinous process of the ilium, passes between the femoral artery and the bone and emerges at the fold of the scrotum. The point being removed, an elastic band is firmly wound figure-of-8 fashion around the projecting ends of the rod, compressing effectually the great vessels. Lisfranc's knife is then introduced a little below the rod, and by cutting from within outwards in the usual way the anterior flap is formed. The vessels being tied, the band and rod are removed and the joint disarticulated and the posterior flap formed. The patient made a good recovery.—*Pacific Med. and Surg. Journal.*

#### A New Method of Amputation of the Upper Extremity.

M. DESPRÉS has devised (*British Medical Journal*) a new method of amputating the upper extremity. It is practicable in patients under 28 years of age, is indicated in cancer of the scapula, and is less formidable than removal of the scapula. It may also be applied in white swelling of the shoulder involving the scapula. The method of operating was as follows: 1. He tied the subclavian artery, external to the scalenus muscle, by a double ligature, to avoid secondary hemorrhage. 2. He made an incision *en raquette*, commencing at the centre of the space separating the eminence of the spine of the vertebrae, at the internal border of the scapula, and at a level with its spine, and following its dorsum, turning round the salient portion of the shoulder and passing under the axilla as far as its centre, and afterward rejoining the original incision at its starting point. 3. He dissected a superior flap without interfering with the incision for the ligature

of the vessel. 4. He divided the clavicle as near as possible to its middle. 5. He tied the axillary vein. 6. The scapula was detached after division of the pectoralis minor and latissimus dorsi, and then dividing the muscles inserted into the scapula. The suprascapular artery should be tied, if necessary, and the wound brought together by sutures. The dangers of this operation consist in 1, the loss of venous blood; 2, the possibility of the entrance of air into the axillary vein; but they are not necessarily mortal. One complication occurred, the extremity of the clavicle perforated the skin; but M. Després thinks that it is better to have such a condition than to remove the entire collar bone, and that this portion of the clavicle preserved covers in the superior aspect of the thorax.—*Med. Record.*

#### The Treatment of Rupture.

D. HAYES AGNEW, M. D., (*Mich. Med. News*): Hernias are in general divided into three classes, viz., *congenital* hernia, or that which exists at birth; *infantile* hernia, or that which comes on after birth, being produced by excessive crying or straining; and *acquired* or adult hernia. To my mind a much better division would be into *congenital* and *acquired* hernia, *acquired* to include the infantile and adult forms. Let us first consider the congenital hernias. A congenital hernia may be either femoral or inguinal. You all know that at about the sixth or seventh month of pregnancy, the child's testicles begin their descent in the inguinal canal. In the act of descending the testicles carry with them that peritoneum which is to form in time the tunica vaginalis testis. After the descent of these bodies, if development goes on properly, a contraction takes place in that part of the inguinal canal just below the external abdominal ring.

This contraction, if it is perfect, shuts off completely the testes from the peritoneal cavity. But suppose that this contraction does not take place? The intestine may at any time slip down more or less through the external abdominal ring and so form a hernia. The same thing may occur in the case of an umbilical hernia. The normal contraction has not been accomplished, and so the intestines find an unnatural means of outlet. In the case of acquired hernia there may not have been perhaps any arrested development, but the ring has not been firmly enough closed to prevent the forcible passage of the intestine. The infant or adult is suffering from a severe acute or chronic cough, strains violently perhaps, when the constriction suddenly dilates and the bowels slip through.

The signs of hernia are divisible into (1) general and (2) special. Under general signs we have to consider (1) the presence of a tumor in certain definite regions\* (a) in the inguinal region, (b) in the groin near Poupart's ligament, and (c) near the navel. (2) We find that the tumor is of variable size, being small at one time and large at another. (3) We are able to notice a decided change in position; the tumor is now present in the scrotum, and now has disappeared entirely from view. (4) The tumor is found to change its position with changes in the position of the body.

When the patient stands upright the tumor is in view; when he lies prone it is gone from sight. (5) Percussion of the tumor, if it be an enterocele alone, elicits a tympanitic sound; if there is omentum alone, and no intestine, the sound will be flat as of a doughy mass; if both intestine and omentum be present, percussion will reveal flatness over one site and elsewhere resonance. (An omentum hernia is more common on the

left than on the right side.) (6) A reducible hernia can always be replaced by manipulation.

The special symptoms of hernia are those referable to the several varieties of the disease. Complete oblique inguinal hernia follows the course of the inguinal canal and makes its way into the scrotum. This form of hernia is to be distinguished from hydrocele by the following special symptoms. (I may say, in passing that the diagnosis between these two affections is not easy, and that the trocar is quite frequently thrust into the contents of an inguinal hernia, mistaking it for hydrocele). (1) If we inquire carefully into a case of hydrocele we will find that the swelling began at the bottom of the scrotum and gradually extended upward: hernia, of course, begins above and goes downward. (2) When the patient lies down, a hernia (that is, a reducible hernia) can be pushed back or will disappear spontaneously. Of course this is not the case with hydrocele. (3) If the tumor be a hydrocele, by taking the patient into a dark room and placing a candle on one side of the mass, being careful to cut off all the rays of light from above it will appear translucent. There would evidently be no translucency if the tumor contained omentum or intestines, unless, indeed, there were a partial dropsy of the sac, in which case part of the tumor would be partly translucent and partly opaque. How is inguinal hernia to be distinguished from scrotal hæmatocele? Hæmatocele is always the result of some strain, blow or fall. But hæmatocele gives like hernia, an opaque tumor. How draw the distinction in this respect? The surest mode of diagnosis is the introduction of a very minute exploring needle. If hernia, no result will be had; if hæmatocele, there will be a few drops of

blood; if hydrocele, a straw-colored liquid. It is generally held that an exploring needle can do no harm, and yet I am not quite sure that it is an entirely innocuous means of diagnosis.

Varicocele is, as you know, an enlargement of the spermatic veins. How is hernia to be distinguished from varicocele? (1) Varicocele occurs almost always (in 999 cases of 1000) on the left side; hernia may be present on either side. (2) When you take hold of a varicocele you find, not a smooth and elastic, not even a doughy feel, but it is as if you had taken hold of a bundle of knotted skeins. A hernia is a smooth and elastic mass. (3) Let the patient take the recumbent position. Both hernia and varicocele would spontaneously disappear. But now press your finger on the external abdominal ring, and let the patient stand up and cough. Varicocele will descend again but not hernia.

So much for the special symptoms of inguinal hernia. There are three kinds of tumors from which femoral hernia is to be diagnosticated—viz., psoas abscess, enlargement of the inguinal glands and varicose enlargement of the saphenous veins where they enter into the femoral veins. What are the main points of distinction? 1. Psoas abscess must follow the course of the psoas muscle. It usually begins from disease of the condyles of the lumbar vertebræ. 2. Psoas abscess comes out of the ring external to the blood vessel; femoral hernia is internal to them. Where there is psoas abscess there is a history of previous bad health, and a general strumous condition of the system. The diagnosis between hernia and swollen inguinal glands is not such an easy matter, particularly as the swollen glands occupy almost exactly the same position as would be held by femoral hernia, lying as they do over the saphenous opening

and near the course of Poupart's ligament. The diagnosis will therefore depend on the following points: 1. If the patient has had any venereal disease, or suffered from any injury to the feet, there is a tolerable presumption that the inguinal glands are swollen. 2. In health the inguinal glands can be isolated. This is also possible when they are diseased, but this process of separation is very difficult when they are glued together by syphilitic exudation. 3. Place your hand on the tumor and tell the patient to cough. There will be a distinct impulse felt if it is an enterocele, otherwise not. (This point of diagnosis is of no value as a mode of distinction between an omental hernia and inflamed glands.) 4. Intestines will give resonance upon percussion; glands dullness. 5. You find upon close examination that the tumor was not always *in situ*; that there has been occasional swelling for years; that the tumor was in the habit of appearing and disappearing. As inflamed glands do not change their place the above facts would argue against their existence. 6. Hernia is usually entirely insensitive to pressure. Inflamed and swollen glands are apt to be highly sensitive. As regards the modes of distinguishing an enlarged saphenous vein from a hernia, they are few and simple. 1. Cough will impart no impulse to an enlarged vein. 2. Press on the vein just below the site of the tumor: if pressure diminishes the size of the swelling, while upon removal of the pressure, it again fills, the tumor is evidently a venous enlargement; otherwise not.

There is but slight difficulty of diagnosis in cases of umbilical hernia. There is rarely any projection except that of hernia in the umbilical neighborhood. This brings us to a consideration of the treatment of hernia. All forms of acquired (adult and infantile) hernia are

curable, provided the hernia be restored and held in position until the hernial passages undergo constriction. Let us take, for example, a case of umbilical hernia in a child. A little tumor makes its appearance at the child's navel, which can be easily pressed back into the abdominal cavity. If the child strains or frets, the projection grows in size. All the treatment necessary in such a case is the accurate application of a truss. You cannot put a truss on too early in such cases. In umbilical hernia the fitting on of a truss is a very simple matter. Take a good-sized cork and cut it into an oval shape, flattening it on one side. Then cut out a strip of sticking plaster long enough to pass entirely round the body. Apply now the oval side of the cork over the site of the hernia, first placing a small piece of chamois between the cork and the skin, and then fasten the cork in position by means of the plaster. Porous plaster is perhaps better than adhesive plaster for this purpose, as it does not irritate the skin so much and will stick much longer. I strongly advise the use of home-made cork trusses in children, as they will keep in position much better and longer than trusses bought at shops.

Where hernia occurs in the adult we have the various styles of artificial trusses from which to choose. These trusses are conical-shaped pads, made of leather, hard wood or ivory, and provided with elastic bands fastened round the body. You will find a great variety of trusses in the market. Some physicians prefer the leather-covered pad on account of the greater comfort allowed by it to the skin; some use the old French truss. In applying a truss for the cure of hernia, there are certain indications which must be carried out to the letter if you expect success in your treatment. The application of a truss,

therefore, calls for the possession of a certain amount of skill. The indications are, (1) the truss ought not to be worn unless it conforms exactly to the person of the wearer; (2) the truss must be so applied as to exert no more pressure than is demanded to keep the hernia in place. I constantly see the effects of the severe and protracted pressure exerted by ill-applied trusses. It is not perhaps so much the amount of pressure employed as where it is employed. As regards this matter of pressure, the old truss made of hard, polished wood, is much more comfortable to the skin than the softer pads. The leather pad in time becomes saturated with perspiration, and so is extremely unwearable. As a general rule, the harder the pad the more comfortable is it to the skin. Pads are either single or double. As a truss, if applied only on one side, is very liable to slide out of position, it is sometimes necessary to use a double truss. I use the Gemrig truss with two pads very often. This truss is double, having two pads both in front and behind. As this truss is intended for one-sided hernia, one of the front pads presses harder than the other. This is a very popular truss. It scarcely ever changes its place.

In the case of femoral hernia, it is very well to employ a movable pad which can be made to drop into the saphenous opening. This movable truss can be changed into a fixed truss for inguinal hernias. Here is a double soft leather truss. This hard rubber truss is very useful. By heating it you can easily model it to fit the outlines of any figure. There are various forms of the hard rubber truss. This specimen does not weigh more than two ounces altogether. It is very inexpensive and never wears out. If the strap is made waterproof, it can be worn in the bath. Here

is another form of truss, constructed for the purpose of controlling hernias which are exceedingly hard to keep in place. It has a projecting centre piece which is supposed to press right into the external abdominal ring, or saphenous opening, whichever the case may be. I do not place much confidence in this form of apparatus. It is but too certain to enlarge the hernial passage at the same time that it is holding the hernia in position.

When you advise any of your patients to use a truss, you should always make it a rule to superintend its first application. If you cannot be present yourself, give your patient the following directions: (1) Never accept a truss until you get one which fits; (2) try it by putting it on, and (a) stooping down and rising up suddenly, (b) by coughing violently and persistently; (c) by separating the limbs and stooping; (d) by crossing the limbs and sitting down; (e) by going through all kinds of motions. Of course the truss is not a proper one if the hernia slips away from it in the course of any of these motions.

In wearing a truss the following precautions must always be had: (1) The patient must never take off the truss till he or she is in the recumbent position: (2) before putting it on again the parts must be rubbed until they are all aglow, so that an active circulation and full secretion are maintained: (3) the truss must be taken off the last thing before the patient retires, and put on the first thing in the morning: (4) in the case of a child, the truss should be worn all the time, both night and day, after the first feelings of discomfort have passed away. At first it must, of course, be taken off two or three times, while the skin is thoroughly rubbed and anointed, and then put on carefully again. If these rules are conscientiously adhered

to, a cure may be expected in the course of two or three years. The truss, at any rate, should not be taken off sooner than that. I may say, in closing, that permanent cure is much more likely to ensue if a hard than if a soft pad has been employed.

#### Some Points on the Reduction of Hernia.

DR. J. S. WIGHT (Proceedings of the Medical Society of the County of Kings):

Seeing that the major operation, or opening the sac, in a case of hernia, is one that may involve great danger, and seeing that the minor operation, in which the sac is not opened, may involve some danger, and seeing that the *taxis* is a safe procedure, especially when it is successful, any expedients that will enable the surgeon to reduce a greater number of hernia, so that fewer operations will be required, will be the means of saving life. In this statement it is implied that cases of hernia are operated on that do not require an operation, and it must be admitted that it is not good practice to operate on a hernia that can be reduced by taxis.

The method of taxis for reducing a hernia, especially one that is strangulated, that I have adopted and advise, may be described as follows:

1. As far as possible grasp the hernial tumor with one hand; this can generally be readily done, except when the tumor is very large. The right hand will be the best adapted for this purpose.
2. Now take hold of the neck of the hernial sac with the thumb and fingers of the left hand, in close proximity to the ring of constricting tissues, which can generally be readily distinguished.
3. Then make gentle traction on the hernial tumor by means of the right hand, when two effects will generally supervene: (1) The hernia will be drawn

out a little and liberated from the ring of constricting tissues; and (2) Some of the fluid contents, and may be some of the solid contents, of the sac, may be felt going through the hernial canal into the abdominal cavity. As the hand pulls on the tumor, it will compress it at the same time, and thus tend to express the contents of the sac. And the contents of the sac will be more apt to be expressed because the hernia is liberated from its constriction.

4. The thumb and fingers of the left hand, as it were, supplement the hernial canal, as they are near the constricting tissues, so that the sac and its contents will be prevented from expanding just outside of the outer end of the hernial canal. In one instance the thumb and fingers will accurately guide the hernial contents into the hernial canal, and in the other instance the hernial contents will swell out around the outer end of the hernial canal. In the latter instance the reduction of the dislocated intestine will be obstructed, and in the former instance its reduction will be greatly facilitated.

5. When the fluid contents of the sac begin to *go back*, then the solid contents of the sac will also begin to *go back*. The left hand of the surgeon must still continue the work it has begun, but the right hand must now, in addition to firmly grasping the hernial tumor, begin to push this tumor toward the external ring, in between the grasp of the thumb and fingers of the left hand, when generally, little by little, and sometimes suddenly, the dislocated intestine will be reduced. Of course, the rules of position and relaxation in regard to the patient should be put in force. When this method of taxis is properly carried out, it will, no doubt, diminish the number of operations for strangulated hernia.

6. In this place I may draw attention to this method of taxis for the purpose of reducing a hernia when the minor operation is performed, since the constriction may be outside the neck of the sac. Also I may call attention to the fact that I have sometimes expanded and stretched, or, perhaps, torn more or less, the constricting band of tissues about the neck of the sac, by means of my finger, which has been pushed up under the edge of this band, carrying the tegumentary tissues before it, thus enabling me to reduce a hernia because the canal has been enlarged. At times I have found this a most valuable expedient, and have never known it do any harm.

#### The Use of the Actual Cautery in the Treatment of Carbuncle.

Dr. P. S. CONNER (*Med. News*), as the result of observation and experience, approves very highly of the use of Paquelin's thermo-cautery in the treatment of carbuncle. He says:

"As the result of my own observation, limited, it is true, but still sufficient from which to draw some conclusions, I am satisfied that by the early application of the thermo-cautery knife, or much better, the hammer-head (if I may so term it, the *foyer en forme de champignon*, of Collin), the pain may be quickly, generally almost at once, relieved, and the progress of the inflammation arrested. The reported observations of others, as those of Verneuil and of Post, confirm me in my opinion. In the cases that I have treated in this way little or no suppuration has occurred, and the eschar has separated in due time, leaving a healthy granulating surface that has soon cicatrized. Even when the carbuncle has been fully formed, and pus has begun to discharge through the skin-openings, I have derived, I believe,

much positive benefit from the thorough application of the cautery, thrust into and through the dead tissue, materially lessening the suppuration, stopping the extension of the disease, hastening repair, and securing a scar deformity decidedly less than that after any other method of treatment.

"Either a white-heat or a dull red may be employed; the use of the latter, of course, being much less likely to be attended with bleeding. In my own cases, no troublesome hemorrhage has been produced by the application of the highly-heated cautery. The after-treatment has been very simple, either dry cotton or hot water dressings being applied until after the separation of the eschar or the slough.

"As every one will admit, the special danger in the severer cases of carbuncle, lies either in the exhaustion consequent upon protracted suppuration occurring in an individual already debilitated, or the subject of grave organic disease, especially of the kidney; or as is more usual, in the great liability to the development of one or other form of blood poisoning. There must, therefore be great advantage in a method of treatment which will promote early separation of the dead tissue, will restrict the suppuration within comparatively narrow limits, and will, as Langenbeck has stated, best secure firm clots and prevent pyæmic accidents. Without presuming to go as far as Vallette has done, in declaring that for carbuncle the actual cautery is 'an unfailing specific, more infallible than quinia in the treatment of intermittent fever;' and fully believing with Trelat, that 'every exclusive method is bad in so far as it is exclusive,' and that the 'treatment must vary according to the progress and form of the swelling, and also according to the general condition of the patient;' I

cannot but think than in other than the milder cases, the use of the thermo-cautery will yield better results, as respects time, suffering and local damage, than any other method of treatment, therapeutic or operative. As in the first day or two, it is often impossible to determine whether the carbuncle is or is not going to run a mild course, as cauterization may abort the disease, and as it is a procedure not specially severe, and not in and of itself dangerous, one certainly would be justified in its early adoption in any case."—*Coll. and Clin. Record.*

### VENEREAL DISEASES.

#### Diagnosis of Pulmonary Syphilis.

Dr. HUGO ENGEL, in an interesting article in the *Med. Times* on pulmonary syphilis, gives the following resumé on the diagnosis of this disease:

"Concerning the diagnosis of pulmonary syphilis, we may mention the following points: first, the history of a specific infection, the primary sore, the bubo, and the symptoms and signs of the constitutional disease; then, possibly, the presence of an ulcer, osteocopic pains, or of marks left by cicatrices of former sores; perhaps also the absence of any hereditary tendency, though in the light of Koch's investigations concerning the true cause of tuberculosis this fact cannot be considered as being of great weight. Lastly, all the symptoms and physical signs of tubercular disease of the lung, accompanied always (such has been observed, at least, in all cases reported so far) by frequent recurrence of a moderate hæmoptysis. But here comes an important point in the differential diagnosis between pulmonary syphilis and pulmonary consumption. In the latter these hemorrhages are not apt to be so frequent. The

sputa in the last stages of phthisis (and it is with the tubercular disease in these stages that lung-syphilis is apt to be confounded) are nummular in form, mostly thick, yellow, while those of pulmonary lues are usually brownish or reddish, sometimes gray, and have those peculiarities which we so fully described above. Another point of differential diagnosis is the fact that the clubbed appearance of the nails (due to absorption of the fat-bolster) is, in the last stages of true tubercular consumption of the lungs, never absent (except, perhaps, in miliary tuberculosis, with which lung-syphilis cannot easily be confounded), while in pulmonary syphilis the nails give evidences of disturbed nutrition, but are never clubbed. The last, but by no means least in importance, is the success of the anti-syphilitic treatment, which, while it might only hasten the unavoidable fate of the consumptive, may, and will always, perhaps, save the life of the syphilitic patient, whom it will restore to comparative health."

#### Subcutaneous Injections of Iodoform in Syphilis.

Dr. THOMANN, of Gratz (*Med. Wiss.*), has treated several cases of intense syphilis by hypodermic injections of iodoform, and generally after ten or twelve such injections, has obtained a notable amelioration of the symptoms. The preparation he uses consists of six parts of iodoform dissolved in twenty of glycerine of this from five to twelve drops may be progressively injected. He has never observed an abscess, but slight swelling and pain may occur at the point where the needle penetrates. Iodine is detected in the urine within two hours after the injection, but no odor of iodoform can be found in the respiration, urine, or cutaneous perspiration. Dr. Thomann has also used a

solution of iodoform in olive oil, but found it much more irritating than the other.—*Med. & Surg. Reporter.*

#### A New Mercurial for Hypodermic Use.

After several years of experimental and practical trials, Professor O. LIEBREICH has at length devised a preparation of mercury, which is especially serviceable for hypodermic use. He announced his discovery at the recent meeting of the Berlin Medical Society. The name of the new compound is formamid of mercury, or *hydrargyrum formamidatum solutum*. Liebreich has found that about thirty injections of a one per cent. solution suffice for ordinary cases of syphilis. Given internally, the drug is inert.—*Med. Record.*

#### Condylomata.

The following powder is commended as a specific for the removal of condylomata:  $\mathcal{R}$  Hydrarg. chlorid. mit., 3 i.; acid. borac., gr. x. Ft. pulv.—*Ibid.*

#### Peculiar Gummy Tumors.

Dr. LEWIN, of Berlin, relates (*Charité Annalen*), three cases in which syphilitic persons had tumors in the palms of the hands, which he considered to be gummata. In the first case that of a man aged forty-five, who had previously been under Dr. Lewin's care for syphilitic affections of the pharynx and larynx, three swellings appeared several years after contagion, on the right palm, and at a later period a swelling on the second phalanx of the thumb. These swellings, as well as another near the internal condyle of the left humerus, were still present when the man was again seen in 1881, ten years after contagion. All of them were diagnosed by the author to be gummata. Subcutaneous injections of mercury, under which the

earlier symptoms had subsided, were prescribed. But after a month there was little change in the tumors. After an interval, inunction of one drachm of mercurial ointment daily was tried, and this also failed to benefit. After a further interval, iodide of potassium was given in a daily dose of thirty grains, gradually increased to forty-five grains. Under this treatment the swellings began sensibly to diminish, some to one-half and others to a quarter of their original size. No further particulars are given.

In the second case, a man aged thirty, noticed, five years after contagion, two swellings in his right palm, and soon afterward a tumor near the left olecranon. Later still, another swelling appeared near the last, and finally a fifth tumor appeared in the left palm. All these swellings were present when the patient, who also had been treated by the author for his earliest symptoms, returned to consult him. There was now, in addition, a swelling of the size of a hen's egg over the second cervical vertebra. Nothing is said about the treatment or termination of this case. In the last case, that of a man aged thirty, nine years after contracting syphilis, two tumors, about the size of a hazel-nut, appeared in the right palm, and one in the left palm. The swellings were almost as hard as cartilage. There was another swelling near the internal condyle of the left humerus. Under iodide of potassium the swellings became somewhat less hard, but did not diminish in size.—*Ibid.*

#### The Treatment of Gonorrhœa.

Dr. F. R. STURGIS (*Med. Gazette*): It is important to bear in mind the distinctions into which the gonorrhœal affections should be divided, according to their seat, viz., urethritis, vaginitis, metritis and the like.

I wish you now to recall some of the points I laid down about the course and progress of a urethritis. First, as to its course: It begins within the first half inch of the urethra, and invades the deeper portions of the canal continuously; and, secondly, as it attacks the different portions of the canal it goes through the different stages of commencement, stasis and decline, marked by different characters in the discharge.

Some cases of clap, especially first attacks, are attended by a very marked amount of inflammation, in which the penis is enormously swollen, hot and red, and in which micturition is only accomplished with extreme difficulty, and in drops often accompanied by blood. In such cases the treatment must be antiphlogistic and expectant. Abstraction of blood by the application of leeches to the external abdominal rings, to the perineum, to the inside of the thighs (never to the penis itself), is both proper and effective, and this should be followed by frequent and prolonged douching of the inflamed genitals in as hot water as patient can bear, to the point of producing faintness. In this stage no injections can be used, and it is probably from non-observance of this rule, and from the attempt to abort a clap by using strong injections that these latter have acquired such a bad name. About this abortive treatment of clap I shall have a few words to say in a minute. For the *ardor urine* I know of nothing that will afford the unlucky patient more comfort than by making him pass his water under water, *i. e.*, in a mugful of hot water. Drugs internally are of little, if any, service; the two best are the homœopathic tincture of *cannabis sativa* given in v-x minim doses every two or three hours, or the oil of cubebs, x-xv minims in the same manner. If the fever run high,

the use of the tincture of aconite root (Fleming's)  $\mathfrak{m}$  j every hour may be used with advantage, but the patient, while using this remedy, should be carefully watched, as the drug is very active and poisonous. The diet should be bland, what is technically called "slops," and all meat, and stimulating food carefully excluded; the drink should be of the same character—milk or water, or the two combined, but nothing else.

When the next stage, that of stasis, is reached, a decided change in treatment takes place. First, all antiphlogistic treatment is stopped, and the patient is placed upon a good, nutritious diet; no starving now, gentlemen, but a healthy regimen. The drinkables, however, are not increased; all stimulants, fermented or distilled, are absolutely forbidden, and the patient's liquid refreshment confined to milk, water, and milk and water, or tea and coffee, of which one-half is milk. But more than this savors of evil, and is not to be thought of. Now is the time for injections, but to be of service they must be properly used. The abortive method, which at one time was frequently tried, I advise you to have nothing to do with. The *modus operandi* was to give one or two injections of a very strong solution of nitrate of silver, and to induce increased irritation in the hope that the greater would remove the lesser. But, vain hope, gentlemen, the course of a clap can seldom be aborted, and the risk run is too great. Severe hemorrhage, œdema of the penis, swelled testicle, and stricture, are some of the penalties paid for this experiment, and I pray you, remember, in this, as in some other instances, that with too great haste there may be less speed. We will adopt, then, what is known as the continuous treatment, and the two requisites are a syringe and a medicated fluid for injection.

Before using the injection the patient should be directed to empty his bladder, and the penis should be grasped between the middle and ring fingers of the left hand, the palm looking upwards. This leaves the thumb and index finger free to open the meatus, which should be done laterally, and not from above downwards. The syringe, being already charged with the injection and freed from air, is then inserted between the distended lips of the meatus, where it is steadied by the index finger and thumb of the left hand, while the index finger of the right hand is placed at the end of the piston of the syringe and gently presses the injection into the canal. If these directions are carefully carried out no fluid escapes. As soon as the urethra is well distended the syringe is rapidly withdrawn and the fingers of the left hand stationed at the meatus are approximated, closing the canal and retaining the injection within, while with the fingers of the right hand, now released from duty, the floor of the urethra is stroked from *behind forwards* to press the injection towards the fossa navicularis, where during the early stage the disease is situated. In the later stages of gonorrhœa this process is reversed, as the disease then lies further back.

The injection is the next thing to be considered, and the simpler it is the better. There are two which I commend for use, viz., the acetate of zinc and boracic acid. They should be used rather weak at first and increased as occasion requires, but should never be made so strong as to produce severe smarting. All that is requisite is a slight degree of warmth for three or four minutes' duration. The following formulæ are the best:  $\mathfrak{R}$  Zinci acetatis, 0.12—0.36—(grs. 2 to 6); Aquæ distil, 30 ( $\mathfrak{z}$  j); and Acidi borac. 0.48—0.96—(grs. 8 to 15); Aquæ distil, 30 ( $\mathfrak{z}$  j).—*Med. Gaz.*

## DISEASES OF THE SKIN.

## Diagnosis of Syphilitic from Non-Syphilitic Psoriasis.

*Syphilitic Psoriasis.*

1. Eruption *not usually* extensive.
2. Patches usually very small, and in shape of spots (size of a split pea) or of small circles or segments of circles (seldom more than an inch in diameter).
3. Elbows and knees usually escape; more on inner than outer aspect of limbs; when limited to soles or palms, most frequently syphilitic.
4. When chronic, eruption usually of a very distinctly coppery tint, sometimes very dark, even nearly black (Psoriasis Nigricans).
5. Scales scanty, thin and greyish.
6. Itching usually absent.
7. May last months, or even more than a year, when no treatment employed.
8. Relapses rare after *all trace* of the eruption has *completely* disappeared.
9. Rarely commences before puberty, and usually after the age of twenty.
10. Can often be traced to infection.
11. Patient often cachectic, and concomitant symptoms detected, *e.g.*, Roseola Syphilitica, Lichen Syphiliticus, Condylomata, Sore Throat, Alopecia, etc.
12. Removal by anti-syphilitic treatment.

*Non-Syphilitic Psoriasis.*

1. Eruption sometimes very extensive.
2. Patches often very large and irregular; when circular, circles often several inches in diameter.
3. Any part of the surface may be attacked, but almost invariably the elbows or knees or head involved.
4. Patches of a dusky-red or light brownish color, as a rule, though may be coppery.
5. Scales thick, imbricated, white, and more silvery.
6. Sometimes not itchy, sometimes intolerably so; generally slightly itchy now and then.
7. Often of many years' duration, or even lasts, on and off, for a whole lifetime.
8. Relapses the rule, and often very numerous, especially in spring and autumn.
9. Many cases commence long before puberty.
10. Is often hereditarily transmitted.
11. Patient generally has a very healthy appearance, and no special concomitant symptoms.
12. Removed by treatment applicable to ordinary Psoriasis, and not benefited by anti-syphilitic treatment.

*Vesicular Syphilides.*

When these occur, and they are rare, they appear generally within three or four months of infection. Usually the vesicles are isolated and some of them may be umbilicated; they are of considerable size, and may resemble those of chicken-pox (hence the term varicella syphilitica), but they differ from it in that the eruption may last for weeks owing to successive crops, that they are more certainly situated upon an elevated base, are surrounded by coppery areolæ, terminate in small greenish scales, and leave coppery stains.

More rarely the vesicles are very minute, and closely act together like those of vesicular eczema (hence the term eczema syphiliticum), but the vesicles do not rupture so readily as those of eczema, are seated on a coppery base, and the secretion dries up into greenish crusts, which, when they fall, leave behind coppery stains; ulcers, too, are much more commonly met with on the patches.—*Medical Times and Gazette.*

**A Study of Herpes Zoster, With Special Regard to its Etiology.**

DR. GEORGE THOMAS JACKSON, (*Med. Record*): Quite early in the era of modern medicine the fact that the zoster groups were located along the course of certain nerves, and these mostly of the spinal system, led observers to surmise that there was some disease of the cerebro-spinal, or at least, the spinal nervous system at the bottom of the trouble. At last, Bärensprung, about the year 1861, originated the theory that zoster was due to disease of the ganglia on the posterior roots of the spinal nerves, or of the Gasserian ganglion of the trigeminus nerve, and since then this theory has been substantiated by himself and others. It is now held that the ganglia becomes inflamed, and the irritation thus set up is carried along the nerves with secondary results on the skin. In some cases hemorrhage takes place into the ganglia. The ganglia being on the posterior or sensitive roots of the nerves, their inflammation would account for the severe pain experienced in zoster. But disease of the nerve-ganglia is not sufficient to account for all the cases of zoster. This may also be caused by disease of the central nervous system, and thus can be explained the occurrence of rare cases of bilateral zoster. It may also be caused by injury or disease of a branch from the main nerve, and be limited to its distribution, or by cancerous or other deposits in the bones of the spinal column. Finally, it may result from atmospheric changes, damp wet weather, sudden arrest of profuse perspiration, poisoning by arsenic, etc.

In studying a number of consecutive cases that have been under my care, I have found in the majority of them so marked a history of mental anxiety, nervous strain or worry, as to lead me

to ask myself the question: "Is not mental anxiety a too much neglected factor in the etiology of zoster?" Of course it would, no doubt, be easy by inquiry to find anxiety and worry in a vast number of ailments, and in many cases they would be but manifestations of the physical state of the patient. But in zoster, some of my patients have given me the history of anxiety without my asking, and the anxious appearance of others has led me to the inquiry. A state of mental unrest will be found noted in four of the cases reported below. Besides these, I have recently seen two other cases having the same factor; one a married lady, enjoying, usually, the best of health, who was attacked suddenly with a very painful zoster after great anxiety in caring for the sick child of a friend; and the other a young man much depressed mentally while passing through the secondary stage of acquired syphilis.

*Pathology.*—In "Virchow's Archives," vol. 86, part iii., 1881, Lesser ("Beitrag zur Lehre von Herpes Zoster") publishes an account of several autopsies upon the bodies of patients dying of zoster, and by microscopical examination of the affected spinal ganglia substantiates the statements made by other pathologists, a summary of which has just been given under the head of *Etiology* in this article. In regard to the secondary changes taking place in the skin, he makes the following (condensed) statement: "The principal changes are in the epidermis, first an increase in the size of the epithelial cells, each one swelling up, in some cases to even five times its usual size, and also an increase in the number of cells; probably by division (*Theilung*). Then little cavities form, containing the altered epithelium, the partition walls being composed of flattened cells; these walls at last break

down and disappear, and thus the vesicles are formed. In the corium under the vesicle there is an infiltration of cells, most marked at the periphery of the vesicle. The blood-vessels are engorged, and in some places he found hemorrhages. All these changes are due to an increased nerve-supply, and increased activity in the nutrition of the cells, followed by degenerative changes, and finally, a giving away of the cells under an increase of exudation from the vessels of the corium.

The *locality* of the eruption will depend upon the nerve affected, and may be anywhere on the body, face, trunk, or extremities. From the localization of the groups the varieties of zoster derive their names, which sufficiently explain themselves, as: Zoster frontalis; Z. pectoralis; Z. dorso-lumbalis, etc.

The *eruption* consists of groups of vesicles upon red bases, the vesicles varying in size from that of a pin-head to that of a pea, or larger, with clear, watery contents at first, becoming in the course of a few days opaque, then purulent, and at last drying into brownish yellow scabs. Each group remains intact eight or ten days, but as new groups are apt to start up, the disease may last several weeks. The vesicles in themselves do not tend to rupture, but are often broken by the rubbing of the clothing. The number of the groups is very variable. In very intense outbreaks some of the vesicles or groups may be hemorrhagic, and cicatrices are apt to remain on healing.

The *course of the disease* is acute, rarely lasting in all more than a month. The eruption is often preceded, accompanied, or followed by severe neuralgic pain, referred at times to the seat of the eruption, at times to the back, etc., as in Z. pectoralis we often find one painful point in the neighborhood of the

spinal column, another in the axillary line where the ribs bend forward at their sharpest angle, the place of bifurcation of the anterior branch of the spinal nerve into its superficial and deep branches, and less frequently a third point near the anterior median line of the chest, where the final spreading out of the terminal branches of the nerve takes place. The pain at these points is aggravated by breathing, thus simulating the pain of acute pleuritis, the diagnosis being at times rendered still more uncertain on account of the pyrexia which may accompany the disease, but, of course, all doubt will fade away on the appearance of the eruption. If the vesicles should break, raw surfaces will be left, which by their attending pain will greatly aggravate the suffering of the patient. The disease is not contagious.

*Sequela.*—In some bad cases, after the lesions proper to the disease have entirely healed, the neuralgic pain will continue for an indefinite period, or there will be lamina of certain muscles, falling out of the hair, or of the teeth. Happily such cases are rare, and the rule is that there will be no sequelae.

*Treatment.*—If the patient suffers much pain, especially if his rest is disturbed by it, he must be kept quiet by the use of opium. Tonics, as iron, strychnia, quinia, etc., are to be used according to the indications present. Phosphide of zinc in doses of one-third of a grain every three hours has recently been recommended. For the neuralgic pains, especially those remaining after the local lesion has healed, Fowler's solution in five drop doses is, perhaps, the best remedy. The constant electric current applied to the seat of the eruption and along the course of the nerves is well spoken of by Duhring, who uses five or ten cells for fifteen or thirty

minutes every day, or twice a day to the relief of the pain, both during and after the eruption, the positive pole being placed over the point of emergence of the nerve, and the negative brushed over the terminal filaments. Locally our object is to protect the delicate walls of the vesicles from rupture, and to this end it is well to use some dusting powder, such as starch, lycopodium, oxide of zinc and lycopodium; one containing morphia and camphor, etc., applied liberally, and then covered with a bandage to prevent the rubbing of the clothing. If the vesicles have burst, leaving a raw surface, powders are still useful, or some simple ointment or unguent zinc oxide, or some anodyne lotion, containing opium, belladonna and camphor, or ac. carbol. gr. 13 or 15 to the ounce of water. Morphia, gr. 10, to flexible collodion,  $\frac{5}{8}$  j., is also good, being painted over the part.

#### DISEASES OF THE EYE AND EAR.

##### Electrolysis in Partial Trichiasis.

Some method of getting rid of individual cilia, without displacement of those in their immediate neighborhood, has long been a desideratum. We often see several hairs growing in a wrong direction on the lid border, the remaining cilia being in a perfectly normal position.

Ophthalmic surgeons have had recourse to one of the following methods for the relief of the above condition: Epilation, which is, however, unsatisfactory, as the irritation of the young hairs will most certainly increase the irritation, which the epilation for a time relieved; the second, or classical method, is snaring of the hair and turning its direction of growth outwards instead of inwards; but the snared hairs are very

liable, sooner or later, to resume their previous vicious direction.

Mr. Arthur Benson, *British Medical Journal*, December 16, 1882, finding these operations unsatisfactory, has adopted the following plan: "To the negative electrode I attach a rather fine gold electrolysis needle, and insert the point of this to a depth of about four or five millimetres along the hair to be destroyed, so that its point should reach well above the root. I then applied the positive electrode to the lid near the outer canthus; contact was conveniently made by wrapping some wet cotton wool round the end of the wire. In a few seconds, the tissues immediately around the needle (negative electrode) began to show white, and soon a distinct bubbling of hydrogen gas could be observed. Half a minute or so, according to the strength of the battery, usually sufficed to completely loosen the hair; I then withdrew the needle, and the positive electrode, and with the fingers or forceps removed the hair. It should come away without requiring the slightest drag, and bring with it a gelatinous-looking mass of dead tissue. If the hair be not sufficiently loose, the needle must be reapplied for a few seconds. The amount of inflammation of the lid resulting is usually not great." In 120 cases so treated no untoward result was seen.

The advantages which the doctor claims for his method, over epilation, snaring, or the actual or potential cauteries, are these: 1. Any individual hair can be destroyed without injuring those beside it. 2. The hair can be got rid of at once and forever. 3. Hairs of any length, strength, or position, can be treated. 4. By its early use, it will render unnecessary many of the more formidable operations on the lids, besides saving the patient much misery.

If applicable for the ciliae, electrolysis should be equally applicable for the destruction of hair-follicles elsewhere in moles, or hairy-faced females.—*Med. and Surg. Reporter*.

**FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.****Antiseptics in Every-Day Practice.**

Dr. W. T. BULL: Wounds of the fingers and hand require most careful cleansing, both of the wound and the parts adjacent, with 5 per cent. solution of carbolic acid, since they are mostly complicated with foreign matters, such as dirt, machine oil, powder, glass, etc. For small incised wounds, neither drains nor sutures are necessary. Careful approximation of the edges by compresses with strips of iodoform gauze (applied like adhesive plaster), covered by cotton and rubber, will suffice to secure first intention. Deeper incised wounds should have a horse-hair or rubber drain, and cut ends of tendons be sutured with carbolized silk cut short. All lacerated and contused wounds, including compound fractures and dislocations with detachment of the skin, should be left to granulate, and no parts removed by operation which are not actually dead. (I am satisfied, from the experience of many cases at the Chambers Street Hospital, that this is the best course to follow. I have often been disappointed in the effort to unite and drain this class of wounds, with a careful Lister dressing too, and had cellulitis follow. On the other hand, the most serious lacerations have, when left open, granulated finely in from five to ten days, without the least local or constitutional reaction, and with moderate and sweet suppuration.) After the irrigation, all recesses of the wound, especially those beneath detached skin and fascia, should be lightly stuffed with iodoform gauze, and the cotton and gutta-percha outside dressing applied to the entire hand and wrist with a splint. In place of the iodoform gauze, the compresses of two

and a half per cent. solution of carbolic acid may be used; but this is not so sure to preserve asepsis, and will need to be renewed every day, if covered with gutta-percha, or kept constantly wet with the same solution. After the wound granulates, useless parts should be amputated, and cicatrization promoted by skin grafting and strapping with adhesive plaster. The most rapid growth of the cicatrix I have found to follow the boracic-acid dressing. The surface and edges are protected with gutta-percha tissue, oil silk, or, best of all, "protective" wet in 5 per cent. solution of carbolic acid. Over this, and projecting an inch or more beyond, comes a compress of lint wet in a saturated solution of boracic acid, and then an elastic bandage, which must be very evenly and smoothly applied. This will require renewal only every third or fourth day. It is more suited to ulcers of the arm and leg, however, where, without exaggeration, I have seen the cicatricial edge advance fully an inch from all sides under one dressing.

In the third class of cases that I have referred to—that of small wounds overlying the greater joints, or the thoracic or abdominal cavity—the greatest care is needed to prevent sepsis. After thorough washing, the discharge should be given free vent through the largest drain the wound will permit (a counter opening is often advisable), and iodoform gauze, or the carbolized (two and a half per cent.) compresses, applied as above described. If one were in doubt whether the cavity was opened or not, it would be best to apply the five-per-cent. solution on a sponge, or (better) to spread a thin film of iodoform on the raw surface. At all events, the wound had better not be tightly sutured; and, on the first appearance of inflammatory reaction, it should

be opened, irrigated, stuffed, and left to granulate under a dressing. In cases of slight punctured wounds, such as are made by sharp hooks, or pocket-knives, it might be safe to dispense with drainage, especially if the wound has been but a short time exposed to the air, and there was no reason to fear the presence of foreign matters; but, in general, I should feel safer from septic influences with a freer wound thoroughly carbolyzed, or iodoformized, and drained, than with a small one left to Nature's sealing process, that of the coagulation of the blood in it. Of course, absolute rest should be enjoined. The following case illustrates the sad result of neglecting this class of wounds: A laborer was brought to the Chambers Street Hospital suffering from suppurative synovitis of one knee joint. A week before he was stabbed over the knee with a pocket-knife, and walked to a doctor's office. A piece of adhesive plaster was applied to the cut; he was told that it amounted to nothing, but recommended to keep quiet. The joint began to swell, but he delayed seeking advice till high fever came on. On admission to the hospital the joint was full of pus, he had pneumonia, pericarditis developed a day or two later, and the autopsy ten days after the injury, revealed pyæmia.

A word of caution as to the infection of wounds by the practitioner himself may be *apropos*. We all know that it is possible to carry the germs of puerperal septicæmia from one woman to another; and it is equally possible to carry germs from a septic wound to a healthy one, and to set up unhealthy action in the latter. It is advisable never to go direct from an erysipelatous patient to one with a healthy wound, and one should never pass from the dressing of one wound to another without elaborate cleansing of the hands with five-per-cent. solution.

The following is a good instance of infection through the surgeon, which came under my notice recently: A dispensary surgeon dressed a hand with severe cellulitis, and a half hour later, without washing his hands, sewed up a slight wound in the cheek of a healthy child, and applied a cold-water dressing. Twenty-four hours later the child was brought back with vomiting, high fever, and erysipelas of the face. Careful inquiry failed to find any source of infection in his surroundings.

Such dressings as I have described cannot be reasonably called complicated. The materials are easily procured, they are easily applied, and without the sacrifice of much time. In the end, from the infrequency of their renewal, and the more rapid course of the healing process, much time is saved to both physician and patient. It is in the power of the physician, by the use of these antiseptic measures, to secure a prompt and inoffensive healing of such wounds as I have mentioned, and to avoid all secondary inflammation. I do not mean to assert that he will be successful in every case. Neglect on the part of the patient, disarrangement of the dressing, or its failure to prevent sepsis, may cause an occasional bad result, but these are conditions beyond his control. But my own experience tells me that if he takes every precaution he will secure the best result in the great majority of cases.—*N. Y. Med. Journal*.

#### Cerebral Hemorrhage and Fracture.

An interesting medico-legal case was brought to the Pennsylvania Hospital recently. A man of intemperate habits was found drunk on the streets, and soon became comatose. He was brought to the hospital with symptoms of compression of the brain without evident hemiplegia, but with irregular pupil

(right strongly contracted), and stertorous respiration, followed by death. There was no discernible wound of the scalp. A hemorrhagic effusion under the membranes, coinciding with a fracture of the right parietal bone, was found in the interior of the left hemisphere, and also a recent clot. It was believed that the small clot first caused apoplexy, and in falling the fracture of the skull was produced. It is further interesting as showing the relation between alcoholic poisoning and cerebral hemorrhage.—*Med. Record.*

#### Treatment of Fracture of the Patella.

In five cases Dr. J. ENGLISH has found the following procedure most successful for the cure of fracture of the patella. He forms a Petit's boot by applying bandages of plaster of Paris and oakum, so that boot and extremity form one solid whole. The broken parts are approximated by a double-headed gutta-percha or flannel roller, so that both heads cross as well above as below in the bend of the knee. The fragments did not heal alone much sooner, but also more perfectly than he had ever seen by any other method. It is by all means rather remarkable, that nobody before should have made use of such an immovable bandage as that of gypsum for fracture of the patella, and English's procedure surely merits a thorough trial by our surgeons also.—*Wien Med. Blatter.*—*Med. & Surg. Reporter.*

#### Dislocation of Astragalus.

In *The British Medical Journal*, Mr. W. HUNT reports a case of forward dislocation of the astragalus, which he succeeded in relieving, without the aid of an anæsthetic, by making extension on the foot, and counter-extension by the arms, and pressure on the dislocated

bone. The result is the more gratifying when we remember that the reduction is difficult and often impossible, without previous division of the tendo Achillis. If all attempts fail, it brings up the vexed question as to the advisability of removing the bone, especially if torsion or version exist.—*Ibid.*

#### A New Point in the Diagnosis of Femoral Luxations.

Dr. TREUB, in reporting a case of obturator dislocation of the femur (*Centralblatt für Chirurgie*, No. 45), calls attention to the value of rectal exploration in order to ascertain the position taken by the head of the bone. In children the foramen ovale as well as the sciatic foramen is very easily examined by the forefinger when inserted into the rectum, and if the head of the femur is in either situation it may be readily felt. In adults it is available especially for the foramen ovale, but by the aid of an anæsthetic and with the hand in the bowel the sciatic foramen may also be explored. The author therefore recommends either for a diagnostic or merely for a demonstrative purpose, in more or less obscure cases of obturator or sciatic luxation, that the rectal method of examination be tried.—*Med. Times.*

#### Dislocations of the Thigh Reduced by New Methods of Manipulation.

In cases where reduction of the femur by manipulation in the usual way, with the aid of anæsthetics, has failed, or is inapplicable, and as a substitute, in many cases, for anæsthesia, assistants, and mechanical power, Mr. KELLEY (*Dublin Journal of Medical Science*) proposes the following methods:

*For Posterior Dislocations.*—The patient is laid prostrate upon the floor. Three strong screw-hooks are inserted into the flooring close to the perineum

and each ilium of the patient, and to these hooks he is secured by strong bandages or rope. The injured thigh is flexed at right angles to the patient's body; the foot and lower extremity of the tibia are placed against the perineum of the surgeon, who, bending forward, with the knees slightly flexed, passes his forearms behind the patient's knee and grasps his own elbows. Reduction is now accomplished by drawing the femur upwards; but circumduction may also be practiced; the surgeon, stepping backwards, then extends the limb, and lays it by the side of its fellow. In sciatic dislocations, in order to liberate the head of the bone from the foramen, a bandage may be passed around the thigh, close to the trochanter, by which an assistant may make traction.

*For Anterior Dislocations.*—The patient is placed upon a table of such elevation as to have his pelvis nearly as high as the trochanter of the surgeon. A bandage around the pelvis, and secured to the side of the table farthest from the dislocation, affords counter-extension. The surgeon, with his face directed towards the dislocated joint, and standing on its inner side, with his trochanter pressed against the femur, now bends the leg behind his back, and grasps the ankle with the corresponding hand. Reduction is effected by rotating or turning his body partially away from the patient, thus making traction on the femur in the most favorable direction, and at the same pressing its head towards the acetabulum with the disengaged hand.—*Ibid.*

#### Transplantation of Muscle.

DR. HELFERICH, of Munich, after the removal of a large fibro-sarcoma from the biceps muscle of a woman, aged 36, refilled the gap left vacant with a fresh-

ly-cut piece of muscle taken from a dog, fastening the same with six lower and thirty upper catgut ligatures. A cure followed the antiseptic treatment. The patient can now readily flex and extend the arm. An electrical examination instituted by Ziemssen did not show any abnormality, and it appears, therefore, that the transplanted muscle has retained its vital function.—*Berliner Klinische Wochenschrift.*—*Ibid.*

#### The Best Material for Ligatures.

In the course of an article on "The Choice of Material for Ligature of Arteries in their Continuity," read in the Surgical Section of the British Medical Association (*British Med. Jour.*), Dr. BENNETT MAY discussed the various kinds of ligatures, and related his experience with them. His conclusions are that stout, common gut, of good quality, improved by long keeping in carbolic oil, is a material for ligature which leaves little or nothing to be desired—*Med. and Surg. Reporter.*

#### The Operative Treatment of Pneumothorax.

The following rules are laid down by Professor WEIL, for the treatment of pneumothorax occurring in phthisical subjects: 1. Most cases of this kind offer but little encouragement for operative interference. Yet in some of even the most hopeless ones an operation may be the means of prolonging life. 2. In some cases with a relatively favorable prognosis, operative procedures may not only prolong life, but may even lead to a complete cure. 3. In the first five or six weeks after the development of pneumothorax, an operation should not be undertaken, unless the dyspnoea become so urgent as to threaten life. 4. If the dyspnoea become severe soon after

the onset of the pneumothorax, and be not controllable by narcotics, then puncture of the chest-wall is necessary. If the dyspnoea speedily return, as it usually does, owing to non-closure of the opening into the lung, an incision must be made. 5. If several weeks later asphyxia threatens, it is due to an accumulation of fluid, which must be withdrawn by aspiration. Should this prove unsuccessful, then there is nothing to do but to make a free incision. 6. In cases with relatively favorable prognosis, it is advisable to operate, even though there be no danger of life. In such cases, however, it is better to wait from four to six weeks, as then the fistula in the lung will probably be closed, and the fever will also have subsided. Various procedures must be adopted, according to the character and amount of the exudation. 7. In cases where the fluid is in excess, and the air has nearly disappeared, the indication is to draw off the fluid in small quantities at a time. 8. In sero-fibrinous exudations we should draw off small quantities from time to time by simple puncture or by the aspirator. 9. If the exudation become purulent, Senator's method must be practised. 10. If a reaccumulation of pus soon take place—the conditions being otherwise favorable—incision must be practised at once. 11. If the fluid remain scanty and the air be unabsorbed at the end of five weeks or more, it would seem to be the most rational plan to let out the gas through the aspirator needle, and so bring the case under the seventh category, where the conditions for further treatment are more favorable. 12. If the case become stationary with a moderate amount of fluid and considerable gas, the withdrawal of both by the aspirator is indicated.—*Wiener Med. Wochenschr.*—*Med. Record.*

#### New Method of Preparing Blisters.

Mr. LIMONSIN has devised a new form of blister, with a view of affording to the physician a greater variety of choice in degree and kind of vesication, and also with a view of preserving the ready-made blister in better condition than is usually the case. He spreads a thin layer of ordinary blistering cerate upon strong, thin, unsized paper, and covers it with the same. The vesicating layer is about one and a half millimetre in thickness, and one of its surfaces is camphorated. When using the blister, its outline is marked upon the paper covering it; it is then cut off and applied to the part by means of a piece of adhesive plaster. The covering paper may be readily removed, both from the plain and from the camphorated side, by means of a wet sponge. If the physician orders a blister covered with oil paper, it is only necessary to saturate the covering paper with oil. The same process may be also used for the preparation of other plasters.—*Rép de Pharm.*—*Ibid.*

#### The Temporary Treatment of Dental Caries.

Dr. SHIRLEY DEACON (New York *Medical Gazette*) gives a mode of procedure by which many carious teeth can be reclaimed instead of sacrificed. A patient suffering from caries of a tooth, connected with abscess of the gum, which causes swelling of the face, should be directed to rinse his mouth well with tepid water. After drying the mouth, absorbent cotton, either in pledgets or twisted into a rope, should be introduced around the tooth, so as to separate it from the tongue and cheek. The cavity must then be cleaned and dried out by means of a bent probe with some absorbent cotton twisted around its end,

keeping the tooth cavity free from saliva and thoroughly dry. The cavity should then be filled with a cotton pellet saturated with the following mixture: Pure phenol, carbolic acid No. 1, half an ounce; glycerine, twenty minims; tannic acid, two drachms. Instead of this precise quantity of tannic acid, as much of it may be used as the carbolic acid solution will take up, adding it slowly, forming a molasses-like liquid, the action of which the author says is quite different from that of either of the chief ingredients used separately. The application is painless, and it quickly desiccates the pulp, rendering it perfectly insensible without appearing to permeate the surrounding healthy dentine to any great extent. A piece of cotton soaked in a solution of mastich or gum-benzoin in ether is applied over the pheno-tannic pellet to protect it from the action of the saliva. Often but one application is needed. Should there be any subsequent tenderness, however, the plug may be changed two or three times a day at first, afterwards once in two or three days. As soon as the patient can bear the necessary manipulation the cavity is to be cleaned out thoroughly and stopped with oxychloride of zinc (os artificial). The author has known this filling to remain serviceable for two or three years.—*Chic. Med. Review.*

#### **Lycoperdon Giganteum as a Hæmostatic.**

In Ireland the giant puff-ball is popularly used as a hæmostatic and surgical dressing. Dr. E. THOMPSON reports (*Lancet*) a case of open cancer of the breast that experienced much relief, not only from lessening of discharge, but also decrease of pain after its use, so that the general health improved and the patient lived for seventeen years afterwards.—*Med. Times.*

#### **Diagnosis of Abdominal Tumors.**

Lo SPALLANZANI has recently published a lecture under the name of Prof. Baccelli on the diagnosis of tumors of the abdomen. We give the following *résumé* of the principal diagnostic points:

Before all, it must be determined whether the tumor is situated within or external to the peritoneal cavity. Extraperitoneal tumors are distinguished by a clear and tympanitic resonance due to the presence of the intestinal mass behind them, it should, however, be remembered that this sign may fail when the intestines are filled with feces, when there is a concomitant ascites, when the tumor attains such a size that it presses on all parts of the abdominal walls, or when the tumor is in contact with some voluminous intraperitoneal organ, such as the liver.

On the other hand, the tympanitic note may be present in the case of tumors of the liver or spleen, if they are covered by intestinal loops.

Observation of the movements of the tumor during inspiration and expiration may give very precise information.

Thus, the intraperitoneal tumor is depressed in inspiration and elevated in expiration. Retroperitoneal tumors, if exploration by the touch is possible, seem to slip under the hand.

Tumors of the abdominal walls, on the other hand, are elevated and depressed in a line perpendicular to the axis of the body because in inspiration the distance between the anterior and posterior walls of the abdomen is increased. An intraperitoneal tumor, however, may remain immovable if it has formed adhesions to the anterior abdominal wall or with the pelvis, or if the diaphragm or lungs are inactive.

A retroperitoneal tumor can also be

movable if displaced, as a floating kidney; or if it is adherent to an introperitoneal organ.

Backward movements of the tumor will be prevented by adhesions to the anterior abdominal wall. If the tumor is small and slightly movable, or independent of the respiratory movements, its change of position can be readily recognized from the exterior.

It is indispensable to study the tumor in connection with the region in which it is found; thus it is known that the kidney may be displaced in front of the liver, and so simulate a hepatic tumor. So also a plural exudation may be mistaken for hypertrophy of the liver.

Tumors of the epigastrium may depend upon the stomach, peritoneal exudation consecutive to some ulcerative process, or upon echinococcus or cancer of the left lobe of the liver.

Tumors of the umbilical region, when not implicating the organs normally in this region, may depend upon a depressed pylorus, on a displaced spleen or kidney, or on a urinary calculus closed in the urachus.

Tumors of the hypogastric region may be caused by the distended bladder, the gravid uterus, ovarian or uterine tumors, or encysted exudations.

Tumors of the iliac and inguinal fossæ can be produced by fecal matter in the cæcum, by neoplasms of the intestine, by abscess, local peritonitis, or affections of the vermiform appendix.

It is also necessary to examine the form of the abdomen to see whether the normal outline has been departed from.

Splenic tumors, in elevating the costal arcs, raise the abdominal walls and give the abdomen a pyriform appearance, with the point directed towards the pubis.

Tumors of the kidney, on the other hand, pressing on the ribs, give the abdomen a very irregular outline.

In the case of tumors of the hypochondrium the umbilicus approaches the pubis and is elongated.

In tumors which are developed deep in the abdomen the umbilicus may be slightly depressed and stretched laterally, and the median raphé slightly deviated to the side on which the tumor is present.

The dilatation of the peri-umbilical veins, the so-called *head of Medusa*, is a sign of obstructed circulation of the portal vein, and is very well marked in central tumors of the liver.

The other dilatations of the epigastric veins indicate interference with the circulation in the inferior vena cava, although obstructed portal circulation may also cause them. It is also necessary to consider displacements of other organs.

In tumors of the spleen the cardiac ventricles maintain their normal position; in tumors of the kidney the stomach is completely displaced; and in large tumors the stomach may form an arc of a circle, its concavity corresponding to the convexity of the internal border of the tumor.

In tumors of the kidney the colon preserves its anatomical position; but when the tumors are very large it may be pushed behind or flattened.

The lower limit of the thoracic cavity must be always accurately limited by percussion, as in tumors on the hypochondrium, which cause tension on the diaphragm, the complementary plural angle nearly always disappears. This is also usually the case of tumors of the kidney. It is also to be noticed that in movable kidneys, in the standing position or even in the dorsal decubitus, a hollow can be observed in the corresponding lumbar region, and the kidney cannot be felt by palpation.—*L'Abeille Méd.—Am. Jour. of Med. Sciences.*

**Practical Conclusions with Reference to Abscesses.**

G. HALSTED BOYLAND, A. M., M. D.  
(*Med. and Surg. Reporter.*)

*Treatment.*—Ordinarily the emptying of pus is the indication of nature. Only seldom, especially in anti-dyscrasic treatment, is it desirable to favor resorption by cathartics, mercurial ointment, painting with iodine, bandage pressure, etc. The opening of an abscess should not be delayed: 1st. When it is seated in the axilla, near the anus or the urethra, particularly when with feces or urine, pus is mixed. 2d. When the pus is situated deep, under fat, fibrous tissues, as for instance, in the hand (also the fingers), the foot, deep in the thigh, etc. 3d. When, from the beginning, important functions are interfered with by the situation of the abscess, *e. g.*, in abscesses of the pharynx and isthmus faucium. Further, those abscesses should be opened early which threaten danger by their proximity to one of the greater cavities of the body, to the cavity of a joint, to important tendons or bones. The operative treatment of abscess resolves itself into punctures, incisions, setons, cautery and blisters. For most small abscesses a simple puncture with the lancet is sufficient. If there is great reason to fear the entrance of air into the cavity of the abscess, a subcutaneous puncture with a trocar is perhaps better, especially in deep abscesses. The entrance of air into wound cavities has gotten to be a great bugbear, and in the treatment of wounds in general, in which I have had a certain measure of experience, I have never seen any evil effects from it. A simple incision and splitting the pus cavity to about two-thirds of its greatest diameter, is oftenest employed in opening abscesses, and best fulfils the indication in phlegmons, perfect and

quick emptying of the pus. The direction and place of the incision are readily determined by the form and situation of the tumor, the long diameter being the one usually chosen. The seton has the advantage of preventing the reclosing of the opening, but leaves an ugly scar. It was for Chassaignac to improve upon the seton, and owing to him it has become almost obsolete in the treatment of abscesses in general. Our present system of wound drainage is based entirely upon his plan. Instead of the seton, he introduced long tubes of gum with numerous openings, through which it is intended the pus shall flow off, and through which injections can be made, if necessary, to cleanse or irrigate a wound surface. The pus does not always flow well through this tube, especially when of a thick, sticky consistency, and in some cases the tube becomes clogged altogether, and the flow is interrupted.

Then free incisions, one on each side of the abscess, should be made at once, in order to obtain unobstructed open drainage. In fact, it were safer to adopt this plan in all swellings that require incision, throughout the whole domain of surgery. During my service on the surgical staff of the French army, in the Franco-Prussian war of 1870-71, we made counter-openings freely. Tubes were used but little. Oftenest not. If the tube is used, it is introduced fastened by a silk thread to an oblique opening (eye) in the point of the stilet. The trocar is first passed through the long diameter of the abscess, and the stilet, with thread and gum tube attached, drawn back, and thus it glides, without difficulty or disturbance of any kind, through the abscess.

Cauterization and blisters merit the lowest place, if they merit a place at all. The former was used, in one case of hot

abscess of the cheek that came under my personal observation; the caustic used was caustic potash, the stick was taken and rubbed over the summit of the abscess until, in a second or two of time, the pus was entirely emptied. It is perhaps a little more painful than puncture or incision, but it leaves a very good, slight and symmetrical scar. This is the only advantage. It is well to employ it for this reason, when the patient is a woman, as the one mentioned was. Hot abscesses are usually single, although I had a case in which there were half a dozen of medium size in different parts of the body, which pointed, broke and healed without treatment, and so rapidly that treatment was really impracticable; they were brought about by too free living on the part of the patient, who had no further trouble as soon as put upon lower diet. The appearance of a small bead of pus on the summit of an abscess is usually regarded as signifying that it is ripe, but do not wait for this if the abscess is red, hot, and fluctuation is distinct. If there is reason to fear that the edges of the incision will close before the cavity of the abscess is entirely filled out, put a wad of charpie in. Emollient cataplasms aid in bringing hot abscesses to ripeness.

In cold or lymph abscesses the contents are, as the name indicates, of a serous or lymphatic character, translucent, with whitish-yellow, caseous flakes, shiny, thready, differing markedly from the pus bonum et laudabile of hot abscesses. Cold abscesses are soft, circumscribed, without pain upon pressure, lying not far under the skin, which retains its normal color. Fluctuation is easily felt. There is no inflammation in the surrounding tissue. The most frequent cause is a dyscrasia. If they grow very large they may, by pressure, then

cause pain in the surrounding parts, in which case the skin above them becomes thin, dark red, and finally breaks through in one or more places. The watery contents already described then flow out, and a fistulous ulcer remains that is very difficult to heal. If such an abscess remains long near a bone the latter suffers with it, becoming carious. It is our first duty to treat the dyscrasia, and to think of local treatment only after the general condition of the patient has been improved; we may then try to bring the abscess to resorption by means of spirituous frictions, painting frequently with tincture of iodine, bandage pressure, cold douche, and, according to Velpeau, blisters. If these do not succeed, and the general health of the patient is better, we may proceed to open a cold abscess, especially if it threatens to break out itself, or threatens a bone by its proximity. It may be opened upon any plan we please, as in this case it is inflammation that we wish to induce, and not to avoid. The same general precautions and rules are applicable in cold as in hot abscess, as regards operative measures. The injection of exciting and irritating medicaments after the opening of the cold abscess with the lancet, is suggested.

Schaack injected red wine or a solution of sublimate or caustic potash; Rust, boiling water. If, after the opening of the abscess, the skin that covers it is very thin, bluish, or near death, it should be cut away with scissors in its entirety, and the wound treated according to remaining indications, generally with stimulating dressings.

#### Strangulated Inguinal Hernia

In very young children is a rare condition. Operations for the relief of this accident have been performed only once in the past ten years at University College

Hospital; once at St. Bartholomew's in the same length of time; six times at St. George's since 1870, on children from five months to two years of age, and twice in seven years at the London Hospital. In all of these cases the patients were boys, and in six out of eight the hernia was on the right side. The sac was opened in all of them, and death followed in only two.

Mr. MARCUS BECK recently operated on a child ten weeks old, and the following account is given (*British Medical Journal*): For four weeks previously a swelling of the right side of the scrotum had been noticed at times, but it had disappeared spontaneously. At the time he was called he found the scrotum distended to about the size of a hen's egg. It was tense, elastic and translucent with fluid at the lower and front portion. The testis could be felt behind the swelling, which extended through the external ring; there was no impulse when the child cried. Taxis was tried, but failed to produce any change in the size of the tumor. It was tapped and about two drachms of fluid drawn off. Taxis without and with chloroform was then tried, but failed, and the operation was then performed. When the sac was exposed an effort at reduction was then made, but unsuccessfully. The sac was then opened enough to admit the finger, and the constriction found at the abdominal ring. An attempt to notch the band with the nail failing, it was stretched and torn by the finger; the bowel was then easily returned. The patient made a good recovery, and three weeks afterwards the hernia had not come down.

The difficulty of diagnosis in this case was owing to the translucency, which was similar to that of infantile hydrocele.—*Chic. Med. Review.*

#### Reduction of Strangulated Hernia Without Operation.

The following simple procedure is stated by Dr. FINKELNSTEIN to have been successfully employed in the reduction of a large number of cases of strangulated hernia: The patient is placed in the ordinary position upon the back, and every fifteen minutes one or two tablespoonfuls of ether, mixed with a little oil, are poured upon the tightly-stretched skin over the intestine. In the course of an hour the bowel usually slips back of its own accord into the abdominal cavity. This action is explained by the author in cases where the strangulation is caused by contraction at the orifice of the hernial sac, as due to relaxation of the inguinal ring from the ether. In other cases, where no contraction exists, Dr. Finkelstein refers the favorable result to a double action of the cold in causing a diminution in size of the knuckle of intestine and in setting up forcible peristaltic movements. The oil is added to the ether, in the proportion of 20 parts to 100, simply to prevent local irritation of the skin.—*Allgem. Med. Central-Zeitung*.—*Med. Record.*

#### Treatment of Neglected Sprains.

Dr. H. A. LATIMER, in the *British Medical Journal*, reports the case of a man suffering from an old sprain of the ankle, of fourteen years' duration. Owing to its being painful, he saved the affected foot and leg as much as possible, resting his weight, when standing, principally on the sound foot. To such an extent did he do this that the muscles of the affected limb commenced to atrophy. Forcible flexion and extension of the joint was made; it was painted with iodine, ammonia liniment was rubbed in daily, electricity twice a

week, and he was ordered to use the limb as much as possible. In three weeks' time a perfect cure resulted, which has been permanent.

#### **Oxygenated Water as a Dressing for Wounds**

At a recent meeting of the Société de Médecine Pratique, M. BROCHIN reported some experiments made by MM. Paul Bert and Becquard, on the use of oxygenated water in the wards of M. Péan for the dressing of wounds. Excellent results had been obtained in cases of purulent cystitis, ozæna, and ringworm. It had also been employed internally in uræmia and diabetes with good results. Its use had not been so successful in obtaining union by first intention as carbolized water. M. Jolly drew attention to the fact, that to preserve oxygenated water, it must contain an acid. This is more frequently hydrofluoric acid, otherwise it may decompose with an explosion; that used by MM. Paul Bert and Becquard contained sulphuric acid, a fact not to be lost sight of. A certain amount of oxygen is liberated from this water in the form of ozone, and it is in this way that it acts.  
—*British Medical Journal*.

#### **Diagnostic Use of the Stomach Pump in Suspected Cancer.**

In the *Centralblatt für Klin. Medizin.*, Dr. ROSENBACH states that in carcinoma of the stomach a diagnosis may be made by examination of the fluid removed by the stomach pump or expelled in the act of vomiting. He says that this fluid always, or at least very frequently, contains small particles of the new growth. These pieces may readily be distinguished with the naked eye from other substances found in the matter removed. Their upper surface is dotted with red, reddish brown, or even black, points—the marks of for-

mer hemorrhages—the coloration sometimes extending deeply into the substance of the separated particles. This surface is smooth, thereby differing from that of any portion of the mucous membrane, which may have been torn off by unskillful employment of the stomach pump.—*Med. Record*.

#### **How to make a Poultice.**

By making a flat flannel bag, in size say twelve inches by eight inches, with one side longer than the other, so that it may fold over the open end like an envelope, according to LAUDER BRUNTON in the *Practitioner*, a valuable means of applying moist heat is furnished. Linseed meal being prepared in the ordinary way with boiling water, the desired quantity of the mass is next introduced into the bag, the flap being then fastened with a few stitches. One or two folds of flannel may be laid between this and the skin; and tapes may be fastened to the four corners to keep it in place. The advantages of this form of poultice are that it may be applied boiling hot without burning the skin, it does not need frequent renewal, it is cleanly, and it is very efficient, especially for the relief of spasmodic pain or abdominal cramps, or in inflammation of the thoracic or abdominal viscera. It is not intended to supersede the ordinary form where the poultice is intended to act directly on the surface, as in wounds, ulcers, and abscesses, but its usefulness is more apparent in medical cases.—*Ibid*.

#### **DISEASES OF THE EYE AND EAR.**

##### **The Theory of Squint.**

In a paper upon the theory of squint (*"Arch. f. Ophth."*, xxviii, 2) Schneller states that a characteristic property of

accommodative convergent squint is that the limits of the visual field remain still within normal conditions. He propounds the question whether every hypermetrope with good visual acuity and accommodation, and with normal muscles, the state of whose eyes is still found within certain specified limits, must necessarily squint? and answers it affirmatively, if the hypermetrope accommodates for the working distance. If, however, a hypermetrope is so circumstanced that he is not obliged to concentrate his attention on fine objects for any continuous period, he will not squint. Another casual factor to be considered in the production of squint is found in the degree of ability the persons possess of recognizing objects in circles of dispersion. This depends on, 1st, the width of the pupil; 2d, on the light-sense; and, 3d, on the sychic power of combination. A third factor in the causation of squint is the power of accommodation. The power of fusion and the necessity for fusion of the images of the two eyes also play a very important part in the causation of squint. —*Ibid.*

#### **A New Method of Applying Remedies to the Eye**

Was advocated by Dr. W. F. MITTENDORF, at the meeting of the Medical Society of the State of New York (N. Y. *Medical Journal*). He prefers to use the remedy in the form of an impalpable powder mixed with gum-arabic and sugar of milk. Eserine may be employed in the same way, but must first be dissolved with sugar of milk, then powdered and afterwards mixed with the gum-arabic. —*Weekly Med. Review*

#### **Central Amblyopia in Diabetic Patients.**

At a late meeting of the Ophthalmological Society of the United Kingdom,

four papers were read upon the amblyopia of diabetics, containing notes of cases. Nine cases were referred to by Dr. EDMUNDS and Mr. NETTLESHIP of failure of sight with central scotoma in the subjects of diabetes, without observed ophthalmoscopic changes. Most of the cases were smokers. The optic nerve of one of these, in which no altered ophthalmoscopic appearances were detected, showed, upon section, changes extending through the length of the nerve, but limited to a central group of fibres, in which there were observed thickening of the connective tissue and degeneration of the nerve-filaments. —*Med. Times.*

#### **Chronic Inflammation of the Eyes.**

H. HOLMES HUNTER, M. D., Sunbury, N. C., writes: I have used the following for a long time with the best results: R Cadmii sulph., 1 grain; aquæ, 1 ounce. M. Sig.: Drop ten or fifteen drops in the eyes at night. —*Med. Brief.*

#### **Tack in the Ear.**

Dr. EDWARD HAUGHTON reports the following case in the *Lancet*: A lady consulted him for deafness and occasional throbbing in the right ear, and on examination with the ear speculum he found a black mass at the bottom of the meatus. Being firmly imbedded with a mass of clotted blood, wax and cotton-wool, it resisted all attempts at removal by the use of a large syringe and hot water; but by the aid of a small artery forceps and a short hook, set in a handle, he succeeded in extracting a carpet-tack, head foremost. As the mass completely plugged up the meatus, in which it had been for years, it was very difficult to extract. She now hears perfectly. —*Ibid.*

**Maxwell's Spot.**

MAYERHAUSEN ("Arch. f. Ophth.," xxviii, 2) has been investigating the subject of Maxwell's spot, and has found that, on looking through glasses which, besides the blue and violet, completely absorb all other rays, the appearance of the spot to his eyes differs in shape from that laid down in other observations. When he held before his closed eye a plane glass of the shade F of Nitsche and Günther's scale and looked toward the sky, and suddenly opened the eye behind the glass, at the very moment of the entrance of the light he saw the extreme periphery of the Maxwell's spot constantly as a six-pointed star, instead of a circle or rhomb. In an albino whom he examined, in whom there was a total deficiency of pigment in the eyes, he found that the yellow coloring matter of the macula was present in normal extent and intensity.—*N. Y. Med. Journal.*

**Deafness following Mumps.**

Dr. JOHANNES SEITZ reports a case of deafness following an attack of parotiditis, but five other cases having been hitherto recorded. The patient, a student nineteen years of age, was seized with inflammation of both parotid glands, of considerable intensity, but unaccompanied with any cerebral symptoms. On the sixth day the patient seemed well. Two days later he returned, complaining of deafness on the right side with tinnitus aurium and dizziness. The watch could be heard only when in contact with the head. The drum of the right ear was thinned, opaque, and slightly sunken, yet the light pyramid appeared normal. On the left side there were evidences of old middle-ear catarrh, but no signs of recent inflammation. There was no complaint of the left ear except for a day or two, when a sound like the

roaring of the wind was present. This soon subsided and no further trouble was experienced on this side. The dizziness and tinnitus continued for two or three weeks and then gradually ceased, but the loss of hearing on the right side remained permanent.—*Correspondenz-Blatt für Schweizer Aerzte.*—*Med. Record.*

**Changes in the Fundus Oculi caused by certain Diseases of the Liver.**

LITTEN (*Zeitschr. f. klin. Med.*, v, 1) has been making some investigations into the changes produced in the fundus of the eye by certain diseases of the liver, with the following results (Dr. Bull in *New York Med. Jour.*): 1. In all the various diseases of the liver which are complicated with icterus, retinal hemorrhages occur not infrequently, and these must be regarded as symptomatic of other widely extended hemorrhagic processes occurring in many of the internal organs. These hemorrhages are by no means always to be regarded as of evil omen, for they occur in a comparatively harmless form of catarrhal hepatic inflammation whenever the latter is complicated with icterus. With the latter they stand in close connection. 2. In one case of acute atrophy of the liver from phosphorous poisoning, besides fresh retinal hemorrhages, Litten observed multiple white spots, which proved, on microscopic examination, to be fatty degeneration, which were mainly situated in the granule layer, and contained numerous granular bodies and tufts of tyrosin. The capillaries had also undergone fatty degeneration. 3. In two cases of atrophic cirrhosis of the liver, he observed pigmentary degeneration of the retina, which in one of the cases was developed long after the disease of the liver had existed, while in the other it preceded it by a year. In both cases

there was marked concentric limitation of the field, with good central vision and general diminution of the visual power under diminished illumination. 4. Hemeralopia sometimes occurs during the existence of a hypertrophic or an atrophic cirrhosis of the liver, without any trace of a demonstrable organic retinal change. 5. By ligation of the optic nerve, as near as possible to the eyeball, it is possible to produce in the retina processes similar to those Berlin describes as produced by division of the optic nerve, and similar also to those seen in retinitis pigmentosa, namely: atrophy of the cellular elements of the retina, absorption of the pigment of the epithelial layer, and wandering of the same into the innermost layers of the retina. On the other hand, a hyperplasia of the connective tissue, as observed in pigmentary degeneration of the human eye, was almost entirely wanting. 6. Immediately after puncture in a marked case of ascites, a neuro-retinitis with slight swelling of the papilla was developed, with exudation into its tissue and around the vessels. Litten thinks that this was caused by the rapid alteration of the conditions of hydrostatic pressure, in consequence of the rapid withdrawal of sixteen litres of fluid.—*Weekly Med. Review*.

#### DISEASES OF THE SKIN.

##### Treatment of Chronic Urticaria.

Dr. G. H. Fox read a paper on the above subject, in which he spoke first of the disease as commonly due to functional disturbance of the abdominal viscera, combined with an abnormal condition of the sympathetic nervous system. To effect a cure we must always depend upon internal medication. An important class are those remedies which tend to eliminate from the blood imper-

fectly oxygenated material. Bicarbonate of soda, 3 ss., in carbonic acid water, half an hour before each meal. Colchicum is also a valuable agent, at the same time abstaining from meat.

Another important class of remedies are those which allay irritation of the gastro-intestinal tract, such as rhubarb, with occasional resort to mineral water. Bismuth, in some cases of gastric irritation, has proved exceedingly beneficial. Sulphurous acid in drachm doses, three times a day in sweetened water, has proved especially efficacious.

A third class of remedies are those which act mainly upon the nervous system, such as quinia, arsenic, etc., Special reference was made to salicylic acid, balsam of copaiba, ergot, nettle-tea, etc.

The conclusion was that the treatment is largely empirical and highly unsatisfactory. The apparent value of drugs has been based partly upon careless observations, and partly upon the fact that the eruption often disappears suddenly without any treatment whatever.

The successful treatment must depend upon a knowledge of its etiology, and a diligent study of the causes of the disease will produce results more conducive to its cure than blind experimentation with remedies.

The paper was discussed by Dr. Rochester, of Buffalo, who spoke of an emetic of epiac. as especially serviceable in the treatment of acute urticaria, and also of some chronic cases of the affection.—*Med. Record*.

##### Warts.

Warts may be removed by the continuous application of mercurial ointment containing five per cent. of arsenic. Prof. UNNA recommends this, or a plaster containing in each 0.2 square meter (eight square inches) ten grams (154 grains) of arsenic and half that quantity of mercury.—*Chic. Med. Rev.*

### VENEREAL DISEASES.

#### The Differential Diagnosis of Hard and Soft Chancre.

Dr. McCALL ANDERSON (*Medical Times and Gazette*):

##### *Infective Chancre.*

1. Four times less frequent than non-infecting chancre.

2. Appears from ten days to six weeks after exposure to infection.

3. Often more like an abrasion of the cuticle than a distinct ulcer; cup-shaped, and with an ash-gray base; rarely attacked by phagedena.

4. Hard, sometimes of almost cartilaginous consistence, and distinctly circumscribed. Induration absent in one-twentieth of cases in men, and oftener in women.

5. Secretion thin, scanty, and watery.

6. Inoculation of secretion produces hard chancre in others, especially if they have not had the disease; but not usually auto-inoculable, because one infecting chancre usually protects the system from a second.

7. Generally solitary, but if more than one chancre they commence at same time, for reason above given.

8. Heals readily unless irritated by treatment.

9. Cicatrix comparatively trifling, and may disappear entirely.

10. Usually followed within a few weeks by indolent non-suppurating enlargement of neighboring glands (in inguinal regions if chancre on penis).

11. Always followed by constitutional symptoms, unless patient had the disease before, when they *may* be absent.

12. Mercury hastens healing of the sore, and disappearance of the induration.

##### *Non-infecting Chancre.*

1. Presumption always in favor of non-infecting chancre, being so much commoner.

2. Appears within two or three days of exposure to infection.

3. A distinct ulcer, usually with perpendicular edges, as if made with a punch; base irregular and honey-combed; often attacked by phagedena.

4. Often some hardness from simple inflammatory infiltration, but never cartilaginous; not so distinctly circumscribed, and although edges may be hard, center usually soft enough to allow sore to be doubled up between fingers.

5. Secretion abundant and purulent.

6. Inoculation of secretion produces soft chancres in person affected as well as in healthy persons, because one soft chancre is no protection against others.

7. Often a succession of soft sores from inoculation of the neighboring parts by pus from original sore, for reason above given.

8. Heals with difficulty, sometimes after months.

9. Cicatrix more marked, and generally permanent.

10. Often followed by absorption of virus from sore, and suppuration of one gland, the pus from which is virulent like that from the sore itself.

11. Never followed by constitutional symptoms.

12. Mercury generally has no effect upon it, or may even retard healing process.

**Blenorrhagic Pleurisy.**

Some years ago M. SEE observed a case of gonorrhœal rheumatism, which was complicated by a distinct inflammation of the pleura. To his mind the pleurisy was evidently due to the venereal disease, since the two inflammations, arthritic and pleuritic, commenced at the same time and without the patient having been exposed in any way that could have produced a pleurisy. He has now added another instance of this rare complication of gonorrhœa (*Journal de Medicine*). This was the case of a young man twenty-five years of age, who had contracted a gonorrhœa some three months previously. He was suddenly taken with chills, pains in his side, fever and dyspnœa, which last was especially marked. Moreover, pressure upon the sides of the thorax induced the most acute pain. Upon his admission into the hospital, he showed evident signs of pleuritic effusion. The dyspnœa was extreme and was not benefited by hypodermics of morphia; but an hypodermic of the nitrate of pilocarpia gave a most excellent result. Dr. P. L. Championnière, in commenting upon the subject, says, that under the condition in which these pleurisies are produced, it is very difficult to prove that they are of a blenorrhagic nature. M. See insists that the thoracic pain and the general instead of the local disorder is sufficient to establish his diagnosis.—*Chic. Med. Review*.

**Small Doses:**

The following are recommended by Dr. A. A. SMITH, of New York: Castor-oil, five drops, rubbed up with sugar and given every two hours in intestinal irritation of children. Tincture of hamamelis, one drop every fifteen minutes as a sedative in children. Tincture of

pulsatilla, one drop in dysmenorrhœa every fifteen minutes, also in orchitis and epididymitis. Fowler's solution, one-half drop in nausea of pregnancy and after a drunken debauch. Tartar emetic, one grain in a quart of water. Dose, one teaspoonful every fifteen minutes in the bronchitis of children. Calomel, one-fiftieth of a grain in syphilitic headache, without gummata, every fifteen minutes. Also in children with vomiting, accompanied with mucous discharges, one-half grain bichloride of mercury in a pint of water, and administered in teaspoonful doses every fifteen minutes; good for the same affections. Fluid extract of ergot, one drop every fifteen minutes in menorrhagia.—

*Medical News*

**Gonorrhœa.**

To reduce the amount of discharge in gonorrhœa: R Aluminis pulv., 3 j.; cubebæ pulv., 3 vij.; myristicæ pulv., 3 ij.; cinnamon powd., 3 ij. M. Ft. chart. No. xx. May be given several times a day.—*Pancoast*.—*New Eng. Med. Monthly*.

**Urethritis in the Female.**

Dr. FISSIAUX relates fifteen cases in which Dr. Leblond treated blenorrhagic urethritis in the St. Lazare Hospital, in the following way: A short stilette is wrapped around with cotton-wool, covered with coal-tar soap; this is passed into the urethra and retained there. It is renewed every other day. During micturition the patient prevents it from falling out by pressing it with her finger. The rationale of the treatment is that the tampon separates the folds of the urethra from each other, and thus keeps the whole surface of the mucous membrane at rest, and in contact with the medicament.—*Med. Brief*.

## FRCTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

### Early Union of Fractures in Children.

The following is a portion of an interesting article by Dr. J. J. BERRY, published in the *New England Medical Monthly*: Surgical writers are, as a rule, somewhat reticent on the subject to be considered; indeed, they often seem to consider the details of bone repair applicable alike to youth and old age—to the invalid and to him of robust health. They are accustomed to divide the process of repair into arbitrary and definite stages; for example, a first, which is from five to ten days duration, and which represents the phenomena of local inaction and inflammatory disturbance; a second, in which the bone undergoes a certain amount of repair; a third, in which shaping of the fragments and partial absorption of callus occur.

If we are content to apply such a description to certain bones in the adult, I believe we would be impressed with its value, being careful, however, to exclude intracapsular fracture of the femur and fractures of the patella, olecranon and acromion processes, which pursue a by no means constant course, and in which we do not expect osseous union.

In young subjects, a description like the one I have just outlined, fails utterly to express the rapidity of repair.

I believe it to be the general impression that although fractures in young children heal somewhat more rapidly, the variation is too slight to influence to a marked degree the duration of treatment, and on looking over the literature of such injuries and finding among the text-books so little to satisfy the inquirer, I am not surprised at the prevalence of such a belief. Hamilton says: "In very early infancy union is accomplish-

ed in half the time required in adult life." In "Holmes' System of Surgery," it is stated that fractures in children unite with marvelous rapidity—ten or twelve days being often sufficient for the forearm or humerus. Agnew says: "I am convinced that the healing of fractures in children takes place at an earlier period than is generally supposed." This is as much, and perhaps more than one would find after a hurried consultation of his surgical works.

The assertions are perhaps unanswerable, but the references are very brief. To such a cause I attribute the fact that surgeons sometimes hesitate to remove splints from disabled limbs even at the expiration of the generally accepted period, fearing that union is not sufficiently firm to warrant it, and anxious to give their patients the possible benefit of such doubt. Such practice is not uncommon, for I have seen many cases of fractured radius in splints three and four weeks—many cases of fractured clavicle retained in a firm dressing four and five weeks—a large number of children with fracture of the humeral condyles obliged to carry the arm at a right angle for four, five and even six weeks.

I believe there are certain instances in which such procedure is demanded—cases occurring in strumous, ill-nourished subjects, in which all constructive action is sluggish and ineffectual, but in young, healthy children such methods seem not only useless but harmful.

The following eight cases are fugitive ones, abstracted chiefly from hospital note-books. In many of them cure had taken place before the date of observation, and consequently the past history and the physical examination of the case were the only facts to be recorded.

CASE I.—Boy, aged five months; fracture of left clavicle at its middle third;

fourteen days standing; union has occurred at an angle but is quite firm.

CASE II.—Boy, eight months old; fracture of right clavicle, junction of middle and outer thirds; ten days standing; firm union.

CASE III.—Girl, eighteen months of age; fracture of right radius; eleven days old; union firm.

CASE IV.—Boy, four years old; fracture of right clavicle at its middle third; ten days standing; union advanced but not complete.

CASE V.—Girl, aged five years; fracture of right clavicle, junction of middle and outer thirds; of eleven days standing; firm union.

CASE VI.—Girl, thirteen months of age; fracture of left radius (Colles'); firm union in nine days; no deformity.

CASE VII.—Boy, two years of age; fracture of internal condyle of left humerus; good union in thirteen days.

CASE VIII.—Boy, three years old; fracture of left clavicle; fair union in twelve days; some angular deformity.

The cases of fractured clavicle received very little treatment; the mothers had from ignorance, either given the accident no attention or else had simply confined the arm in a sling. The one case of fractured condyle had received similar treatment, with the addition of a roller bandage applied over the elbow. As to the exact nature of the injury, it was under the circumstances difficult to decide, but from the location, the small amount of callus, and also the slight displacement observed, it seems probable that several cases were of the incomplete variety. They are interesting from another point of view, as showing the possibility of favorable issues which are independent of surgical skill.

I fortunately have the opportunity of reporting five additional cases which have come under my own observation,

at various times during the past four years, and which have received careful attention from the first. The fractures were, in every instance, complete ones, the fragments being freely moveable and the deformity well marked. The patients were seen a few hours after receiving the injury, and the dressings were applied immediately.

CASE I.—Girl, aged five years; fracture of left clavicle at its middle third; a modified Velpeau dressing; firm union in nine days; little deformity.

CASE II.—Girl, three years of age; fracture of left radius (Colles'); antero-posterior splints used; good union in eight days; no deformity.

CASE III.—Boy, eighteen months old; fracture of right clavicle at its middle third; adhesive plaster dressing, known as Sayre's; firm union in ten days.

CASE IV.—Girl, three years of age; fracture of internal condyle of left humerus; rectangular leathern splint; complete cure in eleven days.

CASE V.—Boy, aged twenty months; fracture of right humerus, middle third, transversely; coaptation and rectangular splints; fair union in thirteen days.

After the removal of the fracture dressings, it was deemed advisable in most cases to apply protective splints, on account of the liability to refracture and bending of the newly united bone, for I would not lead you to infer that the process of union was in any of these cases completed in one or two weeks' time, but rather that at the end of this period, the bony extremities are held so firmly and accurately in apposition, that subsequent repair may progress rapidly and without interruption.

It will be seen that, of the first eight cases, five were instances of fractured clavicle, of which the average duration of repair was eleven and a quarter days.

Of the five last cited, two illustrated the same injury, which healed in nine and ten days, respectively, leaving a balance of time on the side of treatment. It will be also noticed that in the first class of cases, firm union had not taken place in two at the time of the last observation. The first case of fractured condyle reported, healed with some deformity at the end of thirteen days. An almost exact counterpart of this case recovered under treatment, in eleven days, with no deformity.

There are two facts which go far to justify in children the early removal of fracture apparatus. They are: the condition of ankylosis, and the inconvenience and pain resulting from long continued pressure.

It may be urged that no great degree of stiffness is developed in simple fracture. Indeed no less an authority than Verneuil, of Paris, has affirmed that complete rest, however prolonged it may be, produces no hurtful changes in a healthy joint, and he cites much evidence in support of his theory. If this be the case, it seems as though fractures must behave far differently in his hands than in ours in this country,—as though the study of pathology was leading us into devious and unknown paths. It may have been the good fortune of some to treat cases in which no joint complication at any time existed, but I am more certain that many of you recall instances in which passive motion was extremely painful and joint stiffness so marked, as to require many weeks of patient attention and many pounds of muscular strength to restore the disabled parts to their former usefulness.

The general testimony of surgeons is to the effect that prolonged rest acts injuriously upon all the component parts of a joint—the muscles become contracted and undergo atrophy and degenera-

tion; adhesions are formed between the tendons and their sheaths and within the joint capsule; the ligaments shorten; the cartilage grows thick and filamentary; the synovial secretion is arrested, and the nerves suffer changes which pathologically are not understood, but which clinically are evidenced in motor and sensory paralysis and muscular atrophy. These are sequelæ which it behooves us to view in connection with every case of bone injury which we treat, for we are certain to see some of these complications in every limb which has remained four weeks in an immovable fracture dressing. I would therefore suggest that in all cases of uncomplicated injury of the upper extremity in young children, we remove our splints at the end of the tenth day. If we are disappointed with the degree of progress attained no harm will have been done. If we find, however, that union has taken place, it will be in our power to spare the patient a considerable amount of pain and discomfort. This avoidance of pain is a desideratum in adults—especially is it so with children. We know that at this period the nervous system is markedly susceptible; it exaggerates every impression transmitted by it; sources of irritation, which later in life would be insignificant, are at this time destructive. Attention, therefore, to the details of treatment becomes all important.

At the end of two weeks' time, children, as well as adults, seem to become in a measure tolerant of the pressure of splints and accustomed to the discomfort attendant upon perfect joint rest, but in small children especially, there comes a time, usually in a week or ten days, when symptoms of irritation appear; the child becomes fretful and complains of pain. Often very urgent symptoms of reflex irritation develop

and an examination does not invariably show local cause for such manifestations.

The various forms of dressing for fractures about the shoulder, especially if they be composed of adhesive plaster, often entail more suffering than we are apt to appreciate, and which, if the injury be to the clavicle, are little superior oftentimes, to the simple sling and body bandage.

The conviction that my paper is an incomplete one is heightened by my inability to present notes of other than simple fractures; the supposition is, however, that those of the incomplete or impacted varieties heal much more promptly than others.

#### **Belladonna in the Treatment of Hernia.**

W. S. BATTEN reports two cases in which belladonna was used successfully in the treatment of hernia. The first case was that of an old man seventy-nine years of age, who had suffered from hernia for several years. On some unusual exertion he felt the rupture give way, suffered great pain, lay down, and made hot applications to the parts, which, on previous occasions, had given him relief. He continued to treat himself in this way for several days, but there was no evacuation of the bowels, and stercoraceous vomiting set in. Dr. Batten was called in and tried all the customary modes of reducing hernia, but was unsuccessful, as the patient refused to take chloroform. He was then removed to the hospital after taking two grains of opium. There a consultation was held, and the decision reached was that operative interference offered the only chance of saving the patient's life. To this, however, he refused to submit. He was then given half-dram doses of tincture of belladonna every

half hour. In three hours the pupils were largely dilated; there was marked dryness of the throat, and the hernia was returned without difficulty. On a subsequent occasion, where the same condition existed in a slight degree in the same patient, three doses of the tincture of belladonna at half hour intervals made it possible to reduce the hernia with facility.

The second case was that of a pale, pasty youth, aged nineteen, who had been ruptured from childhood. When lifting a heavy load the hernia came down by the side of the truss and could not be replaced. Taxis was attempted after the patient had been fully relaxed by being placed in a hot bath, and then when under the influence of chloroform. Twenty minim doses of the tincture of belladonna, repeated every half hour for four hours, made possible the reduction of the hernia.—*Brit. Med. Jour.*

#### **Treatment of Chronic Abscesses by Injections of Alcohol.**

M. ASSAKY reports fourteen cases of chronic abscess treated after Professor Gosselin's method. This method consists in the injection of alcohol, and is based on antiseptic properties of this agent, and its action on inflamed or suppurating tissues. An incision about a third of an inch in length is first made, and the abscess-cavity, after its contents have been discharged through this opening, is washed out with alcohol of 90 deg. strength. The quantity of injected alcohol varies according to the dimensions of the abscess. It is necessary that the quantity be sufficient for application to the whole of the internal surface of the cavity. The seat of the emptied and injected abscess is then covered by a dressing of camphorated *eau-de-vie*. On the following day there

is an abundant secretion of dark-colored and thick fluid. The secretion diminishes in quantity from day to day, and, as it diminishes its density becomes lower, and its color lighter. In the ultimate stage of the treatment it presents a serous transparent fluid resembling lymph. When, on pressure, this serous fluid only can be forced out, and in small quantity, the abscess is on the point of becoming healed, there is no longer any cavity, the walls are adherent to each other, and there remains but the small incision, which closes in the course of two or three days. This method, M. Assaky states, has the following advantages: It necessitates only a small wound of the integument, and so there is less risk of the ordinary complications of wounds, and the cicatrix is small and is hardly apparent. The superiority of the method, however, consists chiefly in the considerable abridgement it effects in the duration of the treatment of chronic abscess. It is very evident, M. Assaky states, that the number of days occupied in the healing of an abscess by this method, must depend on the extent of the sac. But all other things being equal, the duration of treatment, in a case of abscess punctured and injected after Gosselin's method, is much less than that of one submitted to ordinary methods. In small abscesses, and those of medium size, cure may be effected between the second and seventh days. This treatment may be applied to any chronic abscess that is circumscribed, and consists of one regularly shaped cavity. In most cases, one injection only of alcohol is necessary; but when the abscess is very large, two or three may be required. The indication for a repetition of the injection would be a persistent purulent discharge. The injection of alcohol into the inflamed tissues, it is asserted, is not very painful.

The pain varies with the sensitiveness of the patients. One will complain of lancinating pains, and of burning or pricking sensations which will last from ten minutes to an hour, whilst another will not complain of any painful sensation. Sometimes—though rarely—the injection of alcohol is followed by more or less extensive sloughing of the skin. This result has seemed to M. Assaky to have been usually associated with too long delay on the part of the patient in applying for treatment, so that the seat of the abscess has become much inflamed, and the skin hot, red, and very tense. Associated with this condition there may be a further cause in some faulty diathetic condition of the patient. —*Gaz. Méd. de Paris.*

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#### Cure of Abscesses of the Neck Without Cicatrices.

DR. F. J. B. QUINLAN recommends the passage through the abscess of a fine silver wire, and the ends tied outside, when it will act as a drain. This must be done before the pus reaches the surface, when it is, say half an inch from the external surface. No poulticing or stuping must be used, and when the abscess is evacuated a compress applied. This procedure has never failed in his hands. —*Med. & Surg. Reporter.*

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#### Treatment of Varicose Ulcers of the Leg by Levigated Sub-Nitrate of Bismuth.

It was not my intention to make this report to-day, wishing before doing so to carefully record the result of a large number of cases treated by this method.

Having already treated twenty cases successfully with the sub-nitrate of bismuth, I have only carefully written out the last. This is, however, a typical and conclusive case. I think this case will show conclusively the efficacy of this

remedy in certain ulcers, especially in those of varicose origin.

I propose to continue the use of this treatment, and to report the results, at some future meetings.

Before approaching the subject proper of these remarks, I deem it useful to briefly review with you the varied methods now followed in the treatment of these ulcers.

1. Antiphlogistics were advised, but they are subject to many objections in certain cases.

2. Stimulants, such as aromatic wine, ointments of styras, divers preparations containing red precipitate, solutions of vinegar of different strengths, various mineral acids, more or less diluted; solutions of soap, more or less saturated; solutions of nitrate of silver, perchloride of iron, chloride of lime, blisters, carded cotton, and even the red-hot iron.

All of the above remedies are occasionally useful, but are frequently attended with many disadvantages in their use.

3. The water dressing as used in England.

4. The methodical compression, as effected by carefully-applied flannel bandages, or by strips of adhesive plaster, or emplastrum vigo.

5. Electricity.

6. Incisions, in cases of retarded cicatrization.

7. Destruction of the dilated veins.

8. Lastly, by skin grafting.

I now reach the use of the sub-nitrate of bismuth, of the efficacy of which I was ignorant, until its use was so highly recommended by my friend and colleague, Dr. Mary Durand. The method of its application is as follows:

The bismuth is levigated, which means reduced to an impalpable powder, the ulcers and surrounding skin are carefully sprinkled with this powder to a

thickness of several lines (3 mm.); over this a light pad of cotton wadding, retained in situ by a bandage applied sufficiently tight to create slight compression.

The limb is then placed in a slightly-bent position and absolute rest enjoined. At the end of three or four days this first dressing is removed. If there is found a commencement of cicatrization, which is frequently the case, the adherent scabs are respected, and those that are loose carefully removed. The same dressing is renewed, without washing or cleansing. The third dressing is made after a lapse of three or four days, according to the case. When the process of cicatrization is progressing favorably, dressings are renewed at much longer intervals. After the cicatrization is completed for several days, cold douches are practiced upon the cicatrix to strengthen the tissues; these douches are made with an irrigator or other suitable instrument.

*Mode of Action.*—According to Monnerat, Gintrac and others, sub-nitrate of bismuth is most generally an inert substance, covering the diseased parts, and affording mechanical protection, as it were, against all causes of irritation, similar to that afforded by greasy applications, collodion, and salves generally. Sometimes, however, bismuth becomes a chemical agent, combining with the gaseous emanations, watery exudation, mucus, or acid, and acts as a disinfectant.

This chemical action is proved in the intestinal canal by the production of the sulphide of bismuth, and by another circumstance that the curative and beneficial effects of bismuth are never more evident than when the dejections are blackened and sulphurous.

I am not certain that the action of the sub-nitrate of bismuth may not be due in some measure to the presence of a

certain amount of acid, which it almost always contains in the ordinary specimens found in commerce.

To whatsoever it may be ascribed, the first effects of bismuth locally applied certainly are to rapidly reduce inflammation, relieve pain, and diminish secretion.

Certainly the position of the limb, rest and light bandaging may be considered useful adjuvants in the process of cure. I have witnessed, however, in the invalids under the care of Dr. Mary Durand, the use of the same treatment with the bismuth, the patients allowed to walk and take exercise while under treatment, where the cure was delayed, but not prevented.

In making this communication it is not my object to present a new remedy, possessing infallible action in all cases. No. I wish simply to call attention to a remedy possessing many qualities to recommend its trial in varicose ulcers, where the rapidity of action and the infrequency of repeating dressings are real advantages over many others hitherto employed.—*Journal de Medicine.—Can. Med. Record.*

#### How to Apply the Soda Remedy in Burns and Scalds.

F. PEPPERCORNE, in *Popular Science Monthly*: It is now many years ago (see *London Medical Gazette* of March, 1844) that the author of this paper, while engaged in some investigations as to the qualities and effects of the alkalies in inflammations of the skin, etc., was fortunate enough to discover that a saline lotion, or saturated solution of the bicarbonated soda in either plain water or camphorated water, if applied speedily, or as soon as possible, to a burned or scalded part, was most effectual in immediately relieving the acute burning

pain; and when the burn was only superficial, or not severe, removing all pain in the course of a very short time, having also the very great advantage of cleanliness, and, if applied at once, of preventing the usual consequences—a painful blistering of the skin, separation of the epidermis and perhaps more or less of suppuration. For this purpose all that is necessary is to cut a piece of lint or old soft rag, or even thick blotting paper, of a size sufficient to cover the burned or scalded parts, and to keep it constantly well wetted with the sodaic lotion so as to prevent its drying. By this means it usually happens that all pain ceases in from a quarter to half an hour, or even in much less time. When the main part of a limb, such as the hand and forearm or the foot and leg, has been burned, it is best, when practicable, to plunge the part at once into a jug or pail, or other convenient vessel filled with the soda lotion, and keep it there until the pain subsides; or the limb may be swathed or encircled with a surgeon's cotton bandage previously soaked in the saturated solution, and kept constantly wetted with it, the relief being usually immediate, provided the solution be saturated and cold. What is now usually sold as bicarbonate of soda is what I have commonly used and recommended, although this is well known to vary much in quality, according to where it is manufactured—but it will be found to answer the purpose, although, probably, Howard's is most to be depended on, the common carbonate being too caustic. It is believed that a large proportion of medical practitioners are still unaware of the remarkable qualities of this easily applied remedy, which recommends itself for obvious reasons.

### On the Treatment of Contracted Fingers.

EDWARD BELLAMY, in the *Lancet*: A powerful man some months ago scratched his little finger with a meat bone. The usual train of symptoms followed, and when I saw him the tip of the little finger was so tightly approximated to the palm that no force could separate it, and strong fibrous bands corresponding with the primary flexures were readily observed; and, as I thought the tendon was uninvolved and still ran in a tolerably free theca, I divided the bands with a Von Graefe's iridectomy-knife, which is singularly useful for fine plastic work, and extended the fingers forcibly. No good came of this proceeding. I subsequently placed him under an anæsthetic, and carefully and thoroughly extirpated the entire cicatricial tissues, and divided the tendon, with antiseptic precautions. The finger was carefully retained in the straight position, a metal circlet was made for the wrist, and a piece of stout steel clock-spring welded on to it. This steel spring was carried up the dorsum of the finger and suitably attached to it. By its tension it effectually kept the parts on the stretch, and when the wound had healed, passive and active movements, conducted by the patient himself, brought about an excellent result. The finger is as straight as the others, and will be, no doubt, ultimately quite as useful.

### The Uselessness of Styptics.

In a paper read before the Philadelphia County Medical Society, Dr. J. B. ROBERTS (*Philadelphia Medical Times*) argues with much force against the use of styptics in general surgical practice. He states his objections to their employment in the following propositions: 1. Their reputation as hæmostatic agents

leads practitioners to resort to them when more trustworthy methods are needed. Thus valuable time is lost, for, after temporary arrest, the hemorrhage recurs in the already anæmic patient, and is perhaps followed by disastrous results. 2. If they fail to control the bleeding—which they generally do if the hemorrhage is important—it is often so difficult to rid the surface of the pasty clots that subsequent ligation of the vessels is well-nigh impracticable. 3. Many styptics prevent union by first intention, because they irritate the raw surface, lead to inflammation, or induce suppuration.

He says, further, that Monsel's salt—the subsulphate of iron—has probably more reputation than any other styptic, yet it is the most objectionable of all. It covers the wound with black, sticky clots, which obscure further examination of the surface, prevent primary union, and may even allow bleeding to occur beneath them. I have seen such leathery masses of coagulum raised up into vesicles by the subjacent hemorrhage.

There are but two scientific and satisfactory ways of arresting hemorrhage as usually observed in the practice of general surgery: 1. The first is occlusion of each individual vessel by ligation, torsion, or acupressure, and is generally not required for arteries smaller than the facial, nor for veins, except those of the largest calibre. 2. The second method is direct pressure by compresses and bandages, which, if properly applied, will always be effectual when the first method is not demanded. It is to be adopted when there is oozing from small arteries and capillaries.

In all cases of traumatic hemorrhage it should be recollected that a man can lose many fluid ounces of blood without serious injury, and also that no artery

or vein can bleed if it is compressed by the fingers. These facts assure the surgeon that there are always time and means to control the bleeding, at least temporarily. Many arteries that spurt freely when first divided soon spontaneously stop bleeding. Therefore it is foolish to interrupt the steps of an operation by ligating every little vessel that throws out a jet of blood. Let the surgeon proceed, even if the arteries are quite large, and when he has finished his incisions he will find, to his surprise, very few points requiring ligatures. He should ligate these, and, after washing away the loose clots, make moderate and equable pressure. There will then be no part for styptics to play. It is possible, perhaps, that there may be occasional instances of oozing where pressure cannot be effectually applied; but these are certainly so rare that they do not materially affect the truth of the proposition that styptics are useless.

#### **Treatment of Nævi by Electrolysis.**

The cases for which electrolysis is eminently suited, according to Dr. WILLIAM NEWMAN, are superficial, dark-colored, sluggish, vascular growths, which do not possess special or abundant blood-supply. They waste away after one or two sittings as a matter of moral certainty. Next in order are those nævi which, agreeing with the above in their actual vascularity, yet have much more of surface-covering, and which do not therefore so readily, or to mere inspection, declare the conditions of their blood-supply. A majority of these cases will probably be found to be quite amenable to the electric current. On the other hand, the cases in which electrolysis will not, at least as a rule, succeed, are those which are intensely vascular, which are rapidly growing or have rapidly grown, and which, it is fair to

conclude, have more or less direct communication with blood-vessels near at hand. Especially may this condition be suspected if they are near to vascular trunks, if there be local pulsation, or, again, if there be increase of temperature, a rapid filling after compression, a bright-red color with thinned integuments, all which point to the existence of very free blood-supply. Almost equally unsuitable for this special treatment are the nævi, which are more solid and firm, in which, in addition to the tortuous blood-vessels, there is evidently a large amount of connective tissue. To sum up in a few words, the degree of vascularity present may be taken as a very tolerable guide, and as an indication of the chances of success in submitting any nævus to electrolytic treatment.—*British Medical Journal*.

#### **The Medical Properties of Iodoform.**

Prof. HOFMOKL used iodoform on two hundred patients by the following different methods: as a powder, gauze, emulsion with glycerine and oil, with oil, in the form of rods, salves, plasters, and by the hypodermic injection of ethereal solutions.

After considering the results in all of these cases, he draws the following deductions: 1. Iodoform is an excellent antiseptic medicament, and its application to wounds is painless. 2. On account of its insolubility it is less applicable for complicated or irregular cavities. 3. It does not prevent the inception of erysipelas. 4. It is not a specific against tubercular and scrofulous processes, and produces a favorable result only after the removal of the tuberculous material. 5. It assists in the formation of granulations in fresh and clean wounds, but does not assist in the cicatrization. 6. Very thin layers of iodoform do not prevent union by first

intention. 7. In pharyngeal and laryngeal diphtheria of children, iodoform acts no better than other antiseptics. 8. In wounds and ulcers of the oval cavity, of the rectum, vagina, and in exposed wounds of the bones, the application of iodoform by means of gauze is especially suitable. 9. Injections of the ethereal solution are very painful, but should be tried when all other means fail. 10. It is often useful in goitre (soft) and enlargement of lymphatic glands. 11. It is deleterious in large doses, but is well borne. 12. Childhood is no contra-indication to its use. 13. Previous irrigation of carbolized wounds with carbolized water does no harm, but is unnecessary. 14. The healing of scrofulous and tuberculous ulcers under iodoform does not prevent a return of the disease. 15. Iodoform is excellent for deodorizing necrotic neoplasms. 16. Occasional syringing of suppurating cavities with iodoform emulsion acts favorably on the quantity and quality of the pus formed. 17. The introduction of iodoform pencils into the urethra and bladder relieves the pain in vesical cramp, and delays the decomposition of the urine.—*St. Louis Cour. of Medicine.*

### VENEREAL DISEASES.

#### Treatment of Syphilis.

Dr. MORSE STEWART, Jr., concludes an interesting article in the *Detroit Lancet* as follows: Before going into any details it will be well to glance at the first symptom observable to the patient; the one which in a vast majority of cases leads him to our doors is the initial sore or chancre.

These venereal sores should be treated on general principles and such agents are to be employed as the condition of the sore at the time indicates. In the

first place, the position of the chancre is to be noted, and if we find it on the cutaneous surface of the penis or scrotum, where it occurs in about one-sixth of the cases; the first point to be made is protection from friction or irritation caused by the clothing or body. This can be accomplished by applying a small pellet of absorbent cotton, about the size of a ten cent piece, over the ulcer and holding it in place by a small strip of adhesive plaster or winder, the whole being carried in a suspensory bandage. If, however, the ulcer is on the glans penis, or preputial folds in the male, or on the labial folds in the female the insertion of a small pellet of absorbent cotton will answer to take up the secretion and prevent friction with those parts of the body in close relation.

The frequency in changing the dressings is to be determined by the amount of the discharge, since the dressings should not be allowed to become soaked.

The penis should be supported well up in an appropriate bandage to prevent chafing and favor circulation of the part.

Protection having been thus briefly passed over, let us glance at the hygienic regulation of the affected part. In the first place ablutions and dressings are necessary at least twice a day, morning and evening; these are to be made by means of tepid water and a bunch of prepared lint or cotton which can be destroyed after using; soap not permissible. The part after having been cleansed in the manner described is to be dried by softly pressing lint or absorbent cotton, rubbing and friction to be avoided, after which the ulcer is ready for the dressing. If, however, the chancre is held hidden by phymosis beneath the preputial folds, frequent cleansing by means of a long nozzle syringe filled

with some astringent wash is necessary. The point of the syringe is to be inserted well into the pocket on each side of the penis, and the fluid forced in by means of the syringe. When thoroughly cleansed insufflations of iodoform and starch, equal parts, can be made by means of an insufflator provided with a valve on the tip.

The operation of cutting the prepuce to expose the sore should not be resorted to, for in the case of chancroid, the poison will become inoculated along the whole of the fleshwound. I am sorry to say that I have twice operated this way, and in both instances have had good cause to lament my rashness.

If the œdema is great, hot poultices every two hours will afford great relief, the patient to be kept in the recumbent position, with the penis supported well up. Regarding the various applications resorted to their names are legion, each having its admirers and friends. It is not my purpose here to discuss the merits or demerits of all the remedies advised in treating venereal ulcers, but simply confine myself to such as I have found to answer best in my own practice. To begin with, however, I will make a sweeping condemnation of all greasy or oily applications, except when cicatrization is well begun. In the first place, my preference is for powders of a desiccating, absorbent or alterative nature, as exemplified by bismuth subnitrate, calomel, iodoform, oxide of zinc, biniodide of mercury, gr. i, or ferri sub-sulph., grs. x, starch 3 ij. These I apply by means of a stub camel's hair brush, which is intruded into the mass of the powders, so as to take up a sufficient quantity and then by a sharp tap on the brush the same can be distributed thoroughly over the surface of the ulcer. Iodoform, in my opinion, is the most useful of the powders thus

enumerated, as it is antiseptic, alterative and rapidly promotes healthy granulations upon a sluggish sore. Sometimes after using these powders, especially those made up with starch, we will have a scab crust form over the ulcerating surface, and unless this crust be carefully removed by washing, we will find a closed pocket in which matter will be pent up and thus retard a curative action. Gentle sponging, however, will accomplish the removal of this crust, and then after a thorough cleansing a like application can be repeated. Stimulating lotions are also of service; when the same are required the following may be used with advantage :

℞ Zinci chloridi, grs. ½-1; aq., ʒ i.  
℞ Tr. iodinii, ʒ ¼-½; aq., ʒ i. ℞ Argenti nitratis, grs. ij-v.; aq., ʒ i. ℞ Zinci sulph., grs. i-ij; aq., ʒ i. ℞ Cupri sulph., grs. ij-v; aq., ʒ i.

Or the following astringent lotions :

℞ Pulv. aluminis, grs. x-3 ss.; aq., ʒ i. ℞ Tr. ferri chlor., ʒ ¼-i.; aq., ʒ i. ℞ Tr. myrrhæ, ʒ ½-ij.; aq., ʒ i. and the infusions of hydrastis, coptis or sage.

As alterative lotions, the old-fashioned black or yellow washes are as useful as any, especially where the sores are large and indolent.

Antiseptic lotions are made up from carbolic acid, permanganate of potassium, boracic or benzoic acids. Caustics are used by some for the purpose of destroying the virulency of the sore; but they are then only to be employed when the physician is satisfied of the chancroidal poison, the sores not being large or multiple. In syphilis the caustic treatment will be powerless in destroying the virulency of the sore, as the ulcer is but a local expression of absorption. I have seen several venereal ulcers which, when left alone with nothing but cleanliness, have healed, and

others which, by the injudicious use of caustics, have been kept irritable and spreading. In conditions where the ulcer is indolent and sluggish, caustics may be applied with sufficient frequency to insure the substitution of a healthy action for the morbid condition.

Excision of the chancre is needless, painful, illogical and powerless to abort the secondary manifestations, since the initial sore is not the first expression of absorption, but the action of the poison at the point of inoculation. This procedure is justly condemned by a vast majority of the profession, its clinical results being negative; nor is there any logical reason to hope of its attenuating the syphilitic virus.

The above topical remedies and procedures will, in a vast majority of cases, cure the initial sore, so that a further parade of additional formulæ and remedies will tend to an unnecessary prolongation of this division of my paper.

#### Syphilitic Enlargement of the Tonsils.

An abstract of the conclusions of DR. PAUL HAMONIC is to be found in the *Deutsche Med. Zeitung*, No. 45. Hamonic distinguishes, during the secondary stage of syphilis, (1) *Simple hypertrophy*, which is analogous to the swelling of lymphatic glands, is tardy in its development, and as it occasions no symptoms, is often overlooked. Both tonsils are almost always effected, though to a different degree. The enlargement takes place forwards, bulging the anterior pillar of the fauces, and rarely gives rise to deafness. The tonsils are hard and somewhat elastic; the normal depressions on their surface are exaggerated. The uvula tends to go over to the large tonsil. Sometimes the tonsil may be reduced in size by antisiphilitic treatment. (2) *Hypertrophy associated with angina*.

In this, there is not so much fever as in ordinary acute angina; the duration is variable, and relapses are very liable to happen. (3) *Hypertrophy complicated with syphilides*. Most frequently the syphilide appears on the tonsil and the anterior pillar of the fauces. When syphilis affects a previously scrofulous tonsil, the enlargement is very great, of pale color, often spongy, and with large crypts, there is considerable pain, the voice becomes nasal, and the hearing, taste, and smell are altered. The cause is generally chronic, and there is a great tendency to recurrence. Ordinary tonsillitis and sore throat may supervene even when the tonsils are enlarged from syphilis, but then, though peritonsillar suppuration may occur, it would appear that the tonsil itself never suppurates. Hamonic states that there is no objection to excision of the syphilitic tonsils if they be very large.—*Weekly Med. Review*.

#### Antagonism Between Syphilis and Vaccinia.

Dr. POLIN inclines to the belief (*Annales de Dermatologie et de Syphiligraphie*) that there is an antagonism between the vaccine virus and that of syphilis. He was led to this view by the results of some vaccinations performed by him in Algeria. Of 471 children the vaccination was successful in 410, all of whom were free from any syphilitic taint. Of the 61 children in whom the inoculation did not succeed, 48 presented indubitable evidences of syphilis.—*Med. Times*.

#### Hypodermic Use of Iodide of Potassium.

Dr. GILLES DE LA TOURETTE (*Le Progrès Médical*), draws attention to the hypodermic use of iodide of potassium. He found that it was possible to introduce a syringe of a solution containing 7.5 grains of iodide of potas-

sium, carefully neutralized, without causing any irritation. In twenty injections, only one caused a slight slough. Some burning pain was complained of, which was usually readily allayed by gentle friction with the palm of the hand. The drug was readily absorbed, and could be detected in the urine on the following day. He thinks the method may be of value where there is intolerance of the drug by the mouth, or in cerebral syphilis with coma, and inability to swallow medicines.—*Med. Record.*

#### DISEASES OF THE EYE AND EAR.

##### The Advantages of a Dry Local Treatment in Otorrhœal Diseases.

One of the greatest hindrances to cure in an ear disease accompanied by otorrhœa, whether the disease be due to inflammation in the auditory canal or middle ear, is the presence of granulations and polypoid growths. Yet one of the oldest forms of treatment of otorrhœal disease has been by copious syringing and instillation of various fluid medicines. Hence, in such treatment of this class of aural diseases, moisture has been repeatedly applied to and kept in the ear, a naturally heated locality. Now, as heat and moisture tend to promote granulations and keep up a discharge, it is very apparent that a moist treatment of otorrhœa in many instances has a tendency to keep up rather than to check the morbid discharge from the ear.

On these grounds, therefore, Dr. CHARLES H. BURNETT, in a paper with the above title, in the *American Journal of the Medical Sciences* for January, 1883, holds that the syringe and all forms of drops should be omitted from the home treatment by the patient in cases of otorrhœa. The most the pa-

tient should be directed to do is to dry his ear according to its need, by running into the canal and down to the fundus a twisted pencil of absorbent cotton. The surgeon is to use the syringe only when it is absolutely necessary to remove by it the matter from the ear, and thus prepare the organ for the application of medication by his hand. This latter part of the treatment should consist in the blowing of powders into the ear. Of these, Dr. Burnett recommends one prepared by triturating equal parts of tincture of calendula officinalis with boracic acid (gr. to minim), allowing evaporation, then rubbing one part of the thus calendulated boracic acid with one or two parts of pure boracic acid. Alum should not be used, on account of its tendency to produce furuncles. Comparative tables are given, which show that by the dry method of treatment the average duration of treatment may be shortened from 212 days under the old plan to 34 days by the dry method.—*Ibid.*

##### Acute Inflammation of the Internal Ear.

Dr. VOLTOLINI calls attention, in a monograph published in Breslau, 1882, to the frequency of acute inflammation of the labyrinth (*otitis labyrinthica s. intima*) in young children. He states that it is usually mistaken for epidemic cerebro-spinal meningitis, but that it differs from that disease in its origin, symptoms and sequelæ. He proposes to give it a place among the diseases of childhood, and argues at length against Politzer and others who deny its existence.—*Ibid.*

##### Changes in the Deep Structures of the Eye in Liver Disease:

LITTEN (*Zentral für Augenheilk*) makes the following remarks: 1. In the various forms of liver disease which

begin with jaundice, congested patches are often found in the retina, and even hæmorrhages. 2. In acute atrophy of the liver in cases of phosphorus poisoning, there are often in both eyes multiple points of hæmorrhage. 3. In two cases of liver cirrhosis, pigmentary degeneration of the retina was observed. 4. After puncture for ascites, optic neuritis sometimes ensues. 5. Hemeralopia appears occasionally during hypertrophic and atrophic cirrhosis of the liver, without visible organic change in the retina.—*Canadian Practitioner*.

#### DISEASES OF THE SKIN.

##### Lupus Exedens.

Dr. O. V. THAYER (*Pacific Med. and Surg. Jour.*) concludes an interesting article as follows on the treatment of this disease :

The first indication in commencing the treatment of lupus is to endeavor to modify the general condition by appropriate remedies. The patient should at once be placed under the very best of hygienic influences and proper regimen. The system should be built up as it were. The disease itself is at the same time to be combatted by such external and internal remedies as appear to exert a salutary influence in the development and progress of tubercles and the ulcerative process. Among these are the preparations of iron, iron with bitter compounds, preparations of iodine, mineral waters, sulphur baths. The bath of pure hot water is of more benefit in my estimation than medicated ones.

These should be used often and regularly two or three times a day. The food should be of good quality, well cooked, and taken every six hours. A residence in a dry and bracing atmosphere is a powerful modifier of the constitution.

Among local applications to the ulcer-

ating surfaces, caustics have generally been relied upon—such as the nitrate of silver, potassa fusa, butter of antimony, super-nitrate of mercury, arsenical powders and paste, the actual cautery, and last but not least the solar-ray cautery.

When the disease is extensive, the cauterization should be done with great caution. It should be confined to a single part and extended successively to the whole of the affected surfaces. When the ulcers are covered with scabs, they must be removed or got rid of by means of poultices.

During the treatment patients should avoid exposure to heat or rigorous cold and dampness. For want of attention to this simple precaution, cicatrices that appeared sound have frequently been seen to open out afresh. When the disease is accompanied with any evident functional disturbance it must be remedied by appropriate means.

##### Naphthol in Skin Diseases.

KAPOSI states that care should be observed in the use of naphthol in skin diseases, to avoid surfaces denuded of epithelium, and never to apply it to the entire body. When these precautions are observed, the remedy is wholly without danger, and is of great value in many affections. In eczema it is indicated only in the squamous stage, when the diseased parts are but slightly hyperæmic or even pale. In scabies, one application of naphthol, combined with chalk, green soap and lard, is usually sufficient for a cure. In the various forms of acne, good results follow the employment of naphthol. The remedy is of especial value in the parasitic affections of the skin, as herpes tonsurans and favus. Pediculi are quickly exterminated by a ten per cent. solution of naphthol in olive oil.—*Prager Med. Wochenschr.—Med. Rec.*

**Diagnosis of Lupus.**

Dr. McCall Anderson, (*Medical Times and Gazette*.)

**Lupus Vulgaris.**

1. Commences usually before the age of twenty-five, and often much earlier in life.
2. An indolent, painless affection.
3. Edges of patches, though often round and elevated, are soft.
4. Ulcers in most cases superficial, soft, throwing out profuse granulations, and edges often undermined.
5. The nose is the part of the face oftenest attacked.

**Diagnosis of Lupus Vulgaris.**

Dr. BOECK, of Christiania (*Zeitschrift for practisk Medicin*), in considering the diagnosis and treatment of lupus, points out that some of the earlier Norwegian authors did not always distinguish clearly between lupus and syphilis, a diagnosis which he regards as very easily made in the great majority of cases. He denies any causative connection between the two diseases. At the most, syphilitic parents, in conferring upon the children weakened cell and nerve-life, may favor the development of lupus; but inherited syphilis can only be regarded as a predisposing cause.

In its treatment, the usual hygienic and dietetic rules for scrofulous subjects are to be followed; cod-liver oil is especially useful as a medicament. Locally, the following plaster is recommended:  $\mathcal{R}$  Ol. olivæ; res. colophon.,  $\text{āā}$  8 gm.; ceræ flavæ, 15 gm.; gum. res. ammoniaci; balsam. terebinth. venet.,  $\text{āā}$  1.00 gm.; acidi pyrogallici, 4 gm. M. Fiat emplastr.

After the removal of the plaster the

**Epithelioma.**

1. Occurs usually in persons getting up in years.
2. Tingling, and pain often lancinating in character, common.
3. Edges hard, everted, and often having a glistening, translucent appearance.
4. Ulcers oftener deep, hard, with uneven, finely granular appearance, and exuding a sticky fluid, which gives a varnished appearance to the surface.
5. The nose is not more frequently involved than other parts of the face.

surface is dressed with iodoform.—*Vierteljahrs. für Derm. u. Syph.—Med. Times.*

**Chlorinated Oil in Scabies.**

A new remedy for this affection is made by passing chlorine into olive oil. A compress of cotton saturated with this oil is to be applied night and morning. It is said to be equally efficacious in other parasitic skin affections.

**DIGESTIVE TRACT.****Treatment of Prolapsus Recti by Langenbeck's Method.**

The *Medical Record* tells us that TURBIN reports (*Mediz. Obozr.*) two cases of prolapsus recti cured by the subcutaneous injections of ergot ( $\mathcal{R}$  Extracti secalis cornuti aquosi,  $\mathcal{Q}$ j.; glycerini, aquæ distill.,  $\text{āā}$  3 j. Solve. A syringeful). In one of the cases the prolapsus was reduced by five injections, in the other by nine. A swelling as large as a walnut formed after each injection, disappearing in one to two

minutes under moderate massage by a finger. Pain, though invariably produced, was insignificant.

#### The Treatment of Intussusception.

A prolonged and practical discussion on this subject was had at a recent meeting of the London Clinical Society (*British Medical Journal*).

The whole field of treatment was thoroughly gone over. And the points that should especially claim our attention throughout the course of such cases were brought out clearly and distinctly. There was a pleasant unanimity of opinion, more particularly as regarded surgical interference.

The general consensus of opinion pointed to the early treatment of all cases by inflation and operation. But it was also shown that a great distinction must be drawn between cases of simple intussusception, which may last for weeks when the bowel is not strangulated, and those of strangulated intussusception, in which any delay in operating is to be deprecated, since peritonitis is almost certain soon to ensue. The former cases are those most likely to be benefited by inflation and injection of liquid per anum, possibly the two combined, while the patient's abdomen is kept relaxed by the use of an anæsthetic. But if the strangulation has lasted for some time, and the symptoms are severe, so that there is reason to fear that adhesions may have formed, or the wall of the bowel have become softened by the inflammatory process, inflation or forcible enemata should scarcely then be attempted. Should the case be one of severity and inflation be found valueless, the surgeon should at once have recourse to abdominal section; just as in hernia, when taxis has failed, he directly proceeds to herniotomy.

The median line of the abdomen is to

be chosen for incision, and the operation should be done with antiseptic precautions. The invaginated bowel may be either withdrawn by gentle traction from the encircling portion, or its withdrawal assisted by pushing up from below. Many speakers remarked upon the extreme difficulty they had sometimes experienced in returning the distended bowels into the peritoneal cavity after the operation, a difficulty which may be necessary to overcome by puncture of the intestine with a trocar and cannula, for the withdrawal of gas and liquid. But in cases in which the intussuscepted bowel cannot be withdrawn, what is to be done? As Dr. Buzzard pointed out, the portion of intestine inclosed goes on to slough and separation, and this is nature's method of cure in the very few cases which struggle on to recovery through the various dangers which beset the patient. Surgeons recommended that nature's method should be imitated, as nearly as may be, by a bold excision of all the implicated portion of bowel and the stitching together of the two cut ends. Mr. Howse had already done this in two cases, though as yet without success. To avoid risk of the passage of any fecal material into the peritoneal cavity, he recommended that a thin sheet of gutta-percha material, with a slit in its centre, should be spread before the abdomen, and all the bowel to be operated upon drawn forward through the slit. It might then be treated without fear of fæcal contamination of the peritoneum. It remains to be seen whether this bold procedure of excision will in future result in more success than has hitherto attended it. In certain cases, in which the bowel protrudes through the anus, Mr. Howse would also remove it bodily from that situation by amputation, securing the cut end by pins. An Italian surgeon has already done this by inadvertence, not knowing what he was taking away, and the patient recovered.

# **FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.**

## **Mechanism of a Case of Dislocated Patella with the Bone Standing upon its Edge.**

Dr. EDMUND ANDREWS (*Annals of Anat. and Surgery*): There are few surgeons who have not wondered that a patella could be dislocated so as to stand firmly on its edge, and make in that unstable position strong resistance to reduction. The following case gave an opportunity for dissection, and for a study of the mechanism of the accident: This patient (Case 11,952, *Andrews' Surg. Record*), had his leg crushed by the wheels of a loaded freight-car, producing a compound and comminuted fracture of the tibia and fibula, and a dislocation of the patella upon the external condyle, where the bone stood firmly on its edge. The nature and extent of the injury compelled an amputation at the lower third of the thigh, which was done without reducing the dislocation of the patella, thus securing an opportunity to examine it by dissec-



FIG. 1. APPEARANCE OF THE LOWER END OF THE FEMUR.

tion. It was the right limb. The patella was found shoved nearly straight outward with its inner edge resting firmly against the outer condyle, and with its back and front surfaces presenting in a nearly normal direction. Being thrown completely beyond the articular surface,

its external border projected outward and a little forward as an abrupt prominence under the skin.

Dissecting off the integuments, the mechanism appeared as follows: (1) At the place where the inner border of the patella rested against the femur, the shell and spongy tissue of the condyle were crushed in, making an oval or spoon-shaped hollow about an inch long and five-eighths of an inch wide, as shown in Fig. 1. The sharp inner edge of the patella rested firmly in this hollow or socket, and was thus effectually prevented from slipping.

(2) The rest of the patella was stoutly held in position, like a tent-pole or a derrick, by tight bands drawing in three different directions as follows:

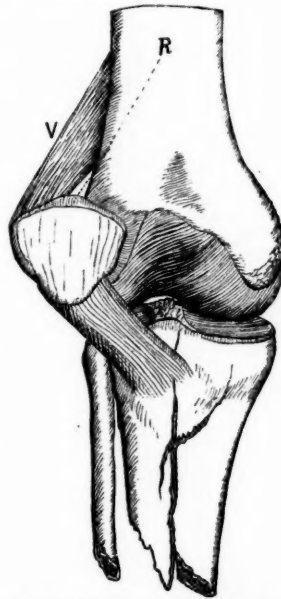


FIG. 2. MECHANISM OF THE DISLOCATION.

R, and the dotted line, show the direction of the traction of the uninjured portion of the rectus; V, portion of the vastus externus muscle.

(a) By a portion of the vastus externus muscle (V, Fig. 2) drawing the outer angle upwards, inwards and backwards.

(b) By a part of the rectus femoris, not represented in the figure, but draw-

ing in the direction of the dotted line *R*, that is to say, upward, inward and forward.

(*c*) By the ligamentum patellæ, drawing downward and inward. All these bands being tightly stretched, the patella was held with great firmness in its seemingly unstable position exactly as the chain and cordage hold the bowsprit of a ship. The vastus internus was torn off, bringing a small bit of the upper and inner angle of the patella with it. The inner half of the rectus was torn off with the vastus internus, and the lateral attachments of the capsular ligament to the sides of the patella were effectually ripped away, but the outer part of the rectus, as before stated, was still attached and drew in the direction of the dotted line *R*.

The cause, therefore, of the firm fixing of the bone in its dislocated position in this case is perfectly clear, and the explanation is probably the same in most other cases of similar displacement.

#### **New Methods of Reduction of Dislocations of the Thigh.**

In cases where reduction of the femur by manipulation in the usual way, with the aid of anæsthetics, has failed, or is inapplicable, and as a substitute, in many cases, for anæsthesia, assistants, and mechanical power, Dr. KELLY proposes the following methods:

*For Posterior Dislocations.*—The patient is laid prostrate upon the floor. Three strong screw-hooks are inserted into the flooring close to the perineum and each ilium of the patient, and to these hooks he is secured by strong bandages or rope. The injured thigh is fixed at right angles to the patient's body; the foot and lower extremity of the tibia are placed against the perineum of the surgeon, who, bending forward, with the knees slightly flexed, passes his

forearms behind the patient's knee and grasps his own elbows. Reduction is now accomplished by drawing the femur upward. But circumduction may also be practised; the surgeon stepping backward, then extends the limb, and lays it by the side of its fellow. In sciatic dislocations, in order to liberate the head of the bone from the foramen, a bandage may be passed around the thigh, close to the trochanter, by which an assistant may make traction.

*For Anterior Dislocations.*—The patient is placed upon a table of such elevation as to have his pelvis as nearly as high as the trochanter of the surgeon. A bandage around the pelvis, and secured to the side of the table farthest from the dislocation, affords counter-extension. The surgeon, with his face directed toward the dislocated joint, and standing on its inner side, with his trochanter pressed against the femur, now bends the leg behind his back and grasps the ankle with the corresponding hand. Reduction is effected by rotating or turning his body partially away from the patient, thus making traction on the femur in the most favorable direction, and at the same time pressing his head toward the acetabulum with the disengaged hand.—*The Practitioner.*

#### **Dislocation of Head of Humerus—Injury to Axillary Artery.**

Three cases of injury to the axillary artery by dislocation of the head of the humerus are reported by KÖRTE in the *Archiv. f. Klin. Chirurgie* (Bd. XXVII., p. 631). 1. Dislocation inwards and forwards; immediate reduction. Formation of traumatic aneurism. Repeated puncture. Septic fever, chills, death from hæmorrhage five weeks after injury. Opening on one side the artery, perhaps from tearing out a branch. 2. Old dislocation forwards and inwards;

repeated efforts at reduction, one of which injured the vessel. Gradual formation of an aneurism. Rupture of the sac, with death. An opening on one side the vessel and fracture of the glenoid margin. 3. Blow on the shoulder, with arm elevated; luxation, with spontaneous reduction; rent in the capsule; aneurism, with ligation of the main trunk. In this case secondary hæmorrhage and renewed ligation. Death from anæmia. Körte has collated thirty-eight cases from the literature of the subject of injury to the artery and four of injury to the vein, but is confident that only a part of the actual number have ever been reported. He shows how, not only reduction of old luxations may cause the accident, but even that of very recent cases. He thinks the use of the foot in the axilla is the cause sometimes; other causes are the age of the patient, his vessels being in an atheromatous condition; too powerful efforts; adhesions of the vascular sheath to the capsule or bone; simultaneous fracture of bone. The symptoms of aneurism have usually been characteristic, though sometimes it has lacked the pulsatile character, while the radial pulse has been felt. He recommends the ligation of the subclavian; or, if compression of this trunk is not temporarily effective, incision and ligature of both ends of the vessel.—

*Weekly Med. Review.*

#### **A New Method of Treatment for Fractures of the Thigh or Leg.**

DR. M. P. FINNEGAN, (*Weekly Med. Review*): I offer the following method of treating fractures of the thigh or leg to the consideration of the profession. In the treatment of fractures, the end for which all surgeons strive is perfect union without deformity, especially in the long bones of the lower extremities,

and for the accomplishment of this object various plans and instruments have been devised, some of them rational, others irrational and barbarous; some have merited the confidence and endorsement they have received, others have been justly rejected. The apparatus which I have used, and which I have found to give the best results, is simple and easily applied, and consists of a leathern cuirass and an elastic extension, and may be described as follows: It is a cuirass or a pair of breeches made of sole leather, hemlock is the best, the waist of which reaches to the axilla and the leg to the malleoli. It should be open in front and have an opening made behind through which the calls of nature may be attended to. It should only be large enough to surround the body and limbs when moulded to them. The leg of the cuirass which is to surround the broken limb should be provided with two strips of wood about one and a quarter inches wide, in each of which there should be two holes, one at the lower end and the other three or four inches above. These strips should reach from the condyles of the femur to four or five inches beyond the sole of the foot, and should be fastened to the leg of the cuirass on each side of the limb by loops or rivets, and in the line of the condyles and malleoli. After the cuirass has been cut to the proper size and shape, it is to be soaked in water until it has become quite pliable, and should then be moulded on some one about the size of the patient and secured in place by a roller bandage until it has dried, which will not take long. It should then be examined to see that there are no sharp points which might produce undue pressure on any part, and should then be well padded with cotton batting or an old blanket. After the fracture has been reduced, which should prefer-

ably be done under chloroform, the parts are to be held in position by an assistant, and two strips of good strong adhesive plaster an inch and a half to two inches wide should be applied to the leg from the site of the fracture to the malleoli, and should be retained in position by a bandage; loops also should be formed at the lower end of these strips and left free. The patient is then placed in the cuirass, which can be made to fit the limb quite snugly by straps and buckles or a roller bandage. Care should be taken that the ankle is surrounded by a sufficient amount of bandaging to prevent the straps from pressing upon the malleoli. A piece of India rubber tubing should be passed through the loops of the plaster and over the cross piece which is fitted in the lower holes in the slats. The surgeon must judge of the amount of extension necessary in each case. A foot piece can now be adjusted for the foot to rest against. In cases of compound fracture a hole should be cut in the cuirass over the wound, which may then be dressed without disturbing the fracture. After pretty firm bony union has taken place, the plaster of Paris bandage may take the place of the cuirass. Since adopting this method I have treated by it seven cases of fracture of the leg and thigh, three of the latter and four of the former, two of which were compound. The result in each case was perfect, except in one of the cases of compound fracture, where there was three-fourths of an inch shortening.

#### **Union by First Intention in Scalp Wounds.**

Dr. ROBERT T. MORRIS, of Bellevue Hospital, N. Y., gives the following directions for securing primary union in scalp wounds:

Let us take for example a typical case.

A man in good health is struck upon the head by a falling beam, and receives a lacerated and moderately contused wound. The wound is a couple of inches long, extending entirely through the skin, and gaping perhaps to the extent of a quarter of an inch. The bleeding is so profuse that the patient comes to you promptly, thereby giving you a great advantage.

Of course the first thing to be done is to make sufficient pressure to control the hemorrhage, and then the hair is carefully trimmed away from the edges and vicinity of the wound. A patient who is bald here finds for the first time a redeeming feature to his condition.

After sufficient hair has been removed a thorough syringing of the wound with carbolized water (1-30) should follow, and then a most thorough search must be made for any foreign body, a single hair left in the cut being sufficient to prevent union by first intention in its vicinity.

Twist together two or three horse hairs which have been kept in carbolized oil and lay them in the wound, allowing the ends to project from either extremity, and then, with a medium-sized curved needle, put in enough silk sutures to bring the edges of the skin closely in apposition, taking care that the needle penetrates the entire thickness of the skin each time that it is inserted.

After all of the sutures have been tied, the horse hairs should be pulled back and forth a little by means of their projecting ends, in order that the canal for deep drainage may be free.

Superficial drainage is next to be looked after, and this end may be gained very nicely by wringing out six or seven thicknesses of cheese cloth in carbolized water (1-30), and applying as a compress on the wound, first rubbing a little

iodoform well into the portion which is to come next the skin. Gutta-percha tissue, or any other waterproof material, should then be placed over the cheese cloth, and the edges allowed to project far enough over so that everything beneath will remain moist and warm. A bandage applied not too tightly completes the dressing.

In twenty-four hours the horse hair may be removed, and the dressings replaced. In forty-eight hours or later, the stitches should be removed, and a warm and dry dressing placed over the site of the wound. If the patient is asked to return for examination in a day or two, the wound will almost always be found to have united beautifully by first intention, and a long period of suppuration, with numerous complications, to have been avoided.

When failure occurs in a case like the one described, the causes are usually due to lack of care in the application of the deep or superficial drainage.

The sutures may have been tied more tightly than necessary, or some foreign material may have been left in the wound.—*Med. Record.*

#### The Treatment of Scalp Wounds.

Dr. W. S. PARKER, of Piqua, Ohio, writes: "An article on scalp wounds in the last number of *The Record* prompts me to communicate a simple device I have used for the last twenty years in such cases. After cleansing the wound thoroughly, all hemorrhage being suppressed, bathe the parts freely with balsam Peru, a time-honored, but none the less valuable antiseptic. Then, presupposing its existence, comb up along the edges of the wound, and exactly opposite, for the space of say half an inch, the hair, which twist into a thread and tie with a *single* turn, drawing the

edges of the wound gently but firmly together. Having previously laid a well waxed ligature beneath the hair and parallel with the wound, tie with the thread the single loop of hair, employing a surgeon's knot. Repeat the process, *i. e.*, another single loop and surgeon's knot, and you have a fixed dressing. The coaptation of the flaps is necessarily perfect. I have not hesitated to use sutures when necessary, owing to the absence of hair or its being too short, or from loss of tissue, and in my entire experience have had but one case of erysipelas following their use, which seems to bear out Professor Gross' teaching of the harmlessness of sutures in the scalp."—*Ibid.*

#### Heaton's Operation.

Dr. T. M. MARKOE (*Medical Gazette*) in a clinical lecture said: Now the next case is one which you have seen before, and it is a man on whom I propose to operate again by Heaton's method for the radical cure of hernia. I have already done this operation twice upon him, with the result of only a very imperfect obliteration of the inguinal canal. He is one of the three or four cases in which I have tried this method, and in none of these cases has the result been entirely satisfactory. But whenever a surgeon of high standing proposes some new operation with which he has himself had good success, I think we should always give these new methods a fair trial, and that we should perform the operation in precisely the same way in which he has done it. So we feel that this method of Heaton's has sufficient testimony in its favor to make it worth our while to try it thoroughly. The operation consists in injecting a solution of white oak into the areolar tissue of the inguinal canal, with the idea that

a sufficient amount of inflammation will be set up in this way to effect a permanent closure of the canal. The solution injected consists of the fluid extract of white oak, with a certain amount of alcohol and ether, to which is added a little morphia. But this addition of morphia I do not like, because if this drug is present in any considerable quantity it bars you from using the solution to any extent you wish. Suppose, for instance, that twenty drops of the solution contain the usual quantity of morphia for a single dose, then if I should wish to deposit three times twenty drops I am prevented, because I fear giving an overdose of the anodyne. And besides, if the morphia is needed, it can easily be injected into the arm in the proper dose. For injecting the solution I use an instrument which varies somewhat from the usual form, and which I suggested and had made for myself. The idea in it is to have a hollow needle with a blunt point of steel which is nevertheless somewhat acuminated, so that it can be run about in the loose areolar tissue of the canal as far and as freely as a sharp needle, while the danger of wounding the adjacent parts is avoided. With a little care you can determine exactly where the point of the needle is going, and you can easily avoid wounding the vein, which is the chief point of danger here.

This man has been operated on three times before this, and two of them were done by me; and there is now a certain amount of solid material effused here, and there is some degree of obliteration of the canal. But I think it needs to be further obliterated by the injection of more of the solution. Operation: My syringe now contains twenty minims of the fluid, and I will be contented with this amount for to-day. At the point where I intend to insert the needle

I first make a small cut through the skin with a sharp knife, and then through this opening I push the needle into the canal, directing it upwards and outwards, and then moving it in any direction I like. And by taking this precaution I can feel the utmost certainty that I have the needle in the canal. Now I deposit a few drops at three different points in the canal, one near the external ring anteriorly, and another directly opposite to this and posteriorly, and another near the internal ring and anteriorly, as nearly as I can locate them. An ordinary broad bandage will be all the dressing needed at present.

#### Treatment of Whitlow.

Prof. NUSSBAUM, of Munich, in a clinical lecture on the treatment of whitlow, seemingly apologises for losing words over so common an affection for which every washerwoman almost has a remedy. Its very commonness, however, makes it important, and the preservation of a finger is often as essential to the usefulness of a man as the preservation of a leg. He asks why whitlow is so often maltreated? He says, as of old, the felon is at first neglected by the patient, then poulticed and in a fortunate event a white point will form, the skin will break and the finger heals. These are the cases which do not come under the observation of the physician. When the latter is consulted the disease is two or three weeks old. The finger has been amply anointed and plastered; the patient did not think it necessary to stop work on account of a sore finger. It is now red or violet, of shining appearance, the skin at a high tension, the finger stiff and immovable, the hand swollen, the pain very intense as far as the axilla, the nights sleepless, the patient has high fever, loss of appetite and

feels as if very sick. Sometimes the skin has already broken and some pus has been discharged. The physician feels whether he can detect fluctuation, and at a suspected point makes a little cut and frees some pus which has collected superficially, and then sends the patient home with directions to make poultices and bathe the finger well. But it does not get better, the incision did no good. The finger swells more, the pain keeps the patient awake all night, he bathes and poultices with no avail; at last, after several weeks it heals, but how? the finger is stiff, or necrosis of a phalanx has set in.

This the professor describes as the course of hundreds of cases, and as the general routine of practice. And now the professor comments on the aid of chloroform and Lister, and says, when such a case of whitlow in the second and third stage comes to you with pain and fever, don't make a small incision which will aggravate the case. The pus, which is the cause of the whole trouble, lies in the depth immediately around the periosteum, and fluctuation can generally not be felt at all. Without anaesthetics you can do nothing. Take a strong bistoury and plunge it in on the radial or ulna side (both if the tension be great) of the affected phalanx down to the bone, and enlarge the cut to the next joint, sparing this of course. Likewise treat the second and third phalanx until the pus is found and the tension relieved. When the hand is much swollen you may suspect pus there too, although it may not be felt, and the knife must be plunged in to the metacarpal bone. Never make the cut on the volar or dorsal side of the finger, in order to avoid the tendons. The cicatrix on the volar surface, especially on the third phalanx, will seriously impair the function of touch. I need not state,

he adds, that Lister's dressing expedites the recovery.—*Weekly Med. Review.*

#### A New Operation for Spina-Bifida.

At a recent meeting of the Leeds Medico-Chirurgical Society (*British Medical Journal*), Mr. ROBSON showed a child six weeks old, upon whom, when six days old, he had performed a new operation for spina-bifida. The redundant parts removed by the operation were also shown. After the removal of these parts and after stitching up the arachnoid over the spinal canal, periosteum from a rabbit was inserted between the meninges and the skin so as to cover the gap in the bones. The wound had perfectly healed; the skin over the lumbar region was quite level; there seemed to be no tenderness on pressure; the child looked strong and healthy. The sac was found to be of the size and shape of half a swan's egg; the wall consisting of true skin and subcutaneous tissue lined by serous membrane. At one point the sac was very thin and transparent, appearing to consist only of the serous membrane covered by a thin layer of epidermis, when fresh minute blood-vessels could be seen to ramify over it. Mr. Robson drew attention to the following points: 1, the operation was performed with full antiseptic precautions, eucalyptus air being used instead of carbolic spray; 2, the meninges were closed by uniting the serous surfaces, as in peritoneal surgery; 3, the transplantation of living periosteum and its continued vitality; it had not yet, however, formed a new bone, but already the covering of the canal had a greater than mere skin-firmness; 4, the entire absence of bad symptoms in the child, operated upon at so early an age, was noticed.—*Med. Record.*

### Digital Exploration of the Bladder--Removal of Vesical Growths.

A remarkable communication by Sir HENRY THOMPSON appears in the *Lancet*, in which the distinguished surgeon reports fourteen cases of digital exploration of the bladder for obscure vesical symptoms, out of which the large number of six occurred, in which vesical tumor was detected and successfully removed, with striking relief to the symptoms. Thirteen of these cases were male, the other being one of a vesical growth in which dilatation of the urethra was practised and the tumor removed, this being added as being analogous to the proceeding adopted in the male. The method pursued in the latter was by a limited incision of the perineum carried to the membranous urethra only; the index finger then being introduced into the bladder, and with the aid of suprapubic pressure with the other hand, the entire mucous surface of the viscus can be explored. Although this incision has been frequently practised for stricture, retention, etc., this application of it for diagnostic purposes is new. Many of the cases in which polypoid excrescences were found had been previously treated for stone in the bladder by lithotrity. In other cases, when no stone, encysted or diffuse, in the form of a calcareous deposit upon the bladder-wall, can be found, the performance of external urethrotomy and the retention of the tube for a few days greatly relieve the symptoms, and the improvement is sometimes permanent.—*Ibid.*

### The Electrical Treatment of Enlarged Glands.

In the *Med. Press and Cir.*, Dr. HERCULES H. MACDONNELL recommends the following modification of Mr. Golding Bird's procedure:

Having selected the gland or mass of

glands you purpose treating, have the surface well cleaned and wiped over with a solution of salt. Apply the negative pole of a Leclanché battery, having two cells connected, over the most prominent part, and the positive about three inches apart; keep moving the positive reophore in a circle round the negative quite slowly, till the electrical stimulus has been sufficiently applied. Usually, five to six minutes is long enough. On the first occasion two cells are enough, as it accustoms the tissues to the action. On the succeeding applications, the effect of additional cells may be tried; but should there be the slightest appearance of inflammatory action, as evidenced by a bluish-white tint under the negative reophore, a couple of cells must be at once disconnected, or the application discontinued on that occasion. I have never used more than eighteen cells continued for three minutes, and have found that from eight to twelve cells give the most satisfactory and rapid results. The length of each application varies for different individuals. In some patients three or four minutes twice daily seemed to suffice; in others a longer application only once answered better. Even different glands or masses of glands in the same individual, progressed more rapidly under varying conditions of length, strength and frequency of application.

Fair-skinned patients bear a more heroic line of treatment better than dark ones, and react more quickly to the electrical stimulus.—*Med. & Surg. Reporter.*

### Mustard and Molasses Plasters

Are recommended by Dr. TYSON, as forming a mild, pleasant counter-irritant, which can be worn for hours.—*Coll. & Clin. Record.*

**Sponge Grafting.**

Dr. P. W. PERKINS CASE contributes an article on this subject to the *Brit. Med. Jour.*, January 13. He uses the finest Turkey sponge, free from grit, etc., which he slices as thin as possible, and soaks in acid nitro-hydrochloric oil for two or three weeks, till all the calcareous and silicious matters are dissolved, when, after repeated washings with water, it has a soft, velvety feel; this, neutralized by washing with liquor ammonia and steeping in carbolic acid solution (1 to 20) for twenty-four hours, is ready for use. A healthy granulating surface is required for it, preferably that of a burn, if there had been loss of subcutaneous tissue. First, he gently scratches the granulations till they bleed slightly, then places pieces of this sectioned sponge about the size of a shilling on the bleeding granulations, and they soak up blood, which, coagulating in the meshes of the sponge, forms thereby a temporary adhesion. The superficial wound-surface, if less than two inches square, is entirely covered with sponge; if more than about two inches square, about half, irregularly, with pieces of that size, and dressed after the Listerian method with oiled silk, six or eight piles of sanitas gauze, guttapercha tissue, and bandage. Sanitas lotion is generally used afterwards at the dressing, it being not so irritating as carbolic acid. The dressings are usually taken down the second day, and the grafts are then found firmly adherent by the coagulum, and comfortable; afterwards dressed every second day; but great discharge requires daily dressing. The sponge seems to become completely organized. —*Med. and Surg. Reporter.*

**Influence of Continuous Cold upon the Deeper Tissues.**

Dr. BAYER formulates the following conclusions from an elaborate series of

experiments made upon dogs: 1. Local abstraction of heat causes a cooling of the neighboring and underlying organs and tissues. 2. The lowering of the temperature of a part is less marked the more distant it is from the cooled surface. 3. The heat-losing property of a given tissue is in inverse proportion to its vascularity. 4. The local cooling announces itself by a more speedy fall of the general temperature. As a practical application of his researches, he states that ice water should not be used as a hæmostatic, since the contraction of the vessels depend upon a continuous application of a moderate degree of cold rather than upon that of a very low degree. He does not, however, deny the efficacy of ice applications in bruises and subcutaneous injuries, but he states that in these cases the deeper tissues do not attain the same degree of cold as when ice is applied directly to the bleeding vessels. They receive only the proper degree of continuous cold to insure the contraction of the blood vessels. The value of local cold applications in inflammations is thus explained: The direct cooling of the tissues depresses their activity. The vessels being contracted, the migration of white corpuscles is restricted, the general temperature is lowered and the heat centre is depressed by reflex influence.—*Zeitschrift für Heilkunde.—Med. Record.*

**Exhausted Linseed Meal for Poultices.**

M. LAILLER (*Rep. de Phar.*) thinks that linseed meal which has been deprived of its oil is superior to that which has been freshly ground and used in its natural state; it retains its heat longer, while when the oil is present it becomes rapidly rancid and seriously irritates the skin.—*Med. and Surg. Reporter.*

**VENEREAL DISEASES.****Syphilis of the Eye and its Appendages.**

Dr. LEARTUS CONNER publishes in the *American Journal of the Medical Sciences*, a paper bearing on this subject, in which the following points are emphasized:

1. The study of specific ocular diseases is helpful in the diagnosis of certain obscure cases otherwise difficult to make out satisfactorily. Thus a specific iritis will at once set at rest all doubts as to the origin of a series of indefinite general symptoms which have annoyed the patient and puzzled the doctor.

2. The careful attention to these cases is the only method by which, in many cases, the eyes can be saved intact during the course of the disease. Surely, when such attention can save eyesight in some cases, it is criminal not to give it to every case.

3. The study of these lesions calls for the most searching examination of the entire organism. Especially is this true of such affections as cannot be distinguished from like diseases of the eye due to far different causes. Thus, if the early treatment of a dacrocystitis be simply local, it is sure to fail if it be of specific origin. Hence, the only chance to avoid failure lies in such an examination as will reveal its specific nature. The same remark applies with even greater force to many other specific diseases of the eye, as will be gathered from his brief review. From this it follows that, in every eye case, the only safe practice is to constantly entertain the possibility of specific infection.

4. The treatment of every specific case calls for constant watchfulness of the eyes with the ophthalmoscope, other-

wise lesions impossible to repair may be established before the practitioner is aware of their existence or of any danger. Perhaps in no class of troubles is it more apparent that the general and special knowledge of morbid phenomena need to be constantly combined in one person. The special practitioner needs to be a general one, and the general practitioner a special one. — *Med. Record.*

**The Pathology of Intestinal Syphilis.**

Syphilitic lesions of the intestines are, according to KUNDRAT, very seldom met with in adults, being more commonly found among the manifestations of hereditary syphilis. Yet even here they are comparatively rare, Kundrat and Marzek having seen but nine instances among two hundred cases of infantile syphilis. In all of these cases syphilis of other organs was also present. The small intestine appears to be oftener attacked than the large, in the proportion of about four to one. Two varieties of the affection present themselves. In the first the process is essentially localized, and is confined usually to Peyer's patches and the solitary follicles. In the second the disease attacks the entire circumference of the canal. The mucous membrane presents a velvety appearance, and about Peyer's patches is of a dark red color. Little pits are seen in the surface of the patches, giving a cribriform appearance to the part. In the second form little nodules are scattered over the inner surface of the intestines, of the size of a hemp-seed, or smaller. The meconium is thickened and adherent to the wall of the intestine. The peritoneum is usually of a pale red color and presents numerous points of syphilitic growth about the vessels. In more severe cases there is a fibrinous exudation covering the peritoneum.

A diagnosis of this variety of visceral syphilis is evidently a matter of some practical importance. But it is not always possible to make it. As regards the treatment of luetic affections of the alimentary canal, the same general principles which govern all cases of congenital syphilis are applicable to this class of cases.—*Ibid.*

#### Gonorrhœa and Joint-Complications— Gonorrhœal Rheumatism (b).

After a review of the literature of this subject, Dr. W. NOLEN, of Rotterdam, is disposed to be sceptical as to the occurrence of true articular rheumatism as a complication, properly speaking, of gonorrhœa. He concludes that (1) occasionally gonorrhœa does become complicated with disorders which can be described as rheumatic. (2) In comparison with the frequency of the occurrence of the gonorrhœa, such accidents are exceptional. (3) The aforesaid disorders show the greatest variety in their extent and intensity; there is no such thing as a characteristic gonorrhœal rheumatism. (4) Since those persons who during an attack of gonorrhœa suffer with joint-inflammations are liable with subsequent invasions of gonorrhœa again to have articular seizures, it seems that the urethral inflammation does exercise some influence over the appearance of the complication. (5) The manner in which the gonorrhœa causes this complication is not clear. (6) Since the articular complication only very exceptionally occurs, and the symptoms show nothing characteristic, it can be concluded with certainty that the gonorrhœa attains the rôle of an occasional and not a determining cause. (7) The principal cause of the development of rheumatic complications, therefore, must be looked for not in the gonorrhœa itself, but in the affected individual. (8) It is also to

be borne in mind that persons who contract gonorrhœa are also very liable to be exposed to other sources of injury, such as cold, excesses in drink, fatigue, etc., and that in many cases of so-called gonorrhœal rheumatism there may be only an accidental coincidence of rheumatic disease and gonorrhœa. In those cases, however, where it is necessary to acknowledge that gonorrhœa may occasionally give rise to rheumatic complications, it may be explained through a reaction of the gonorrhœa upon the whole organism (it is known that gonorrhœa may cause a slight fever and gastric disorder), so as to affect the physiological condition of some of the tissues, and thus is able, in susceptible persons, to give rise to rheumatic affections.—*Deutsches Archiv. für Klinisch. Med.—Med. Times.*

#### Treatment of Gonorrhœa.

A rather large number of American, German, French and English physicians have—as we see by reading through the many different foreign and domestic medical journals—of late been reporting very successful results in the treatment of gonorrhœa by the *yellow* oleum santali. We learn that the remedy invariably puts an end to the discharge within two days, but to prevent a relapse it has to be continued for two weeks longer. From 15 to 20 drops, given three times daily, is the usual dose, which may be administered on sugar or in gelatine capsules.—*Ibid.*

#### Treatment of Paraphimosis.

Dr. O'CONNOR of the Limerick Hospital recommends (*British Medical Journal*), as an improvement in the treatment of paraphimosis the winding of ordinary twine firmly and closely from before backwards around the constricted portion of the penis. By this

procedure the exudation is driven backward, and on unwinding the twine after a short time the prepuce comes readily forward. He has resorted to this device on several occasions with invariable success and with the causation of but a trifling amount of pain.—*Can. Med. Record.*

#### Bromide of Potassium in Chordee.

In the *Bull. de Therap.*, Dr. CAMBILLARD states in a recent thesis that he has seen this painful affection successfully treated at the Midi by means of injections of bromide of potassium, and supplies the following formula: Water, 150 parts by weight; glycerine, 10; bromide of potassium, 6; and Resseau's laudanum, 2 parts. Four of these injections should be employed in the twenty-four hours, the last just before bed-time. Each injection should be retained one or two minutes. The erections are usually speedily calmed, and sometimes completely suppressed. They are nowise painful, causing only in some persons a slight burning sensation. They act by anæsthetizing the urethral mucous membrane.—*Med. and Surg. Reporter.*

#### Simonnot's Anti-Blennorrhagic Boluses.

The *Jour. de Med. de Paris* gives this formula:  $\mathcal{R}$ . Copaiba balsam, 3 vj.; powdered cubebs,  $\mathfrak{z}$  iij 3 viss.; wax, 3 iij.; powdered rhatany, 3 ij $\frac{1}{2}$ ; carbonate of magnesium, 3 iss. To be made into boluses of 15 grains each, which are to be rolled in subcarbonate of iron, and coated with an ethereal solution of tolu balsam and mastic.—*Ibid.*

#### Treatment of Bubo.

Dr. HERMANN KÜMMELL employs a dressing of bichloride of mercury after the extirpation of an inguinal bubo. He removes the whole group of glands, and

not merely those that are affected. After the extirpation of the glands the wound is thoroughly dried with sponges, drainage-tubes being inserted into the deeper pockets, if necessary. The edges of the wound are then approximated by sutures, except for a short space at the lower edge, which is left open for drainage. The surface over the wound cavity is now covered with pads of gauze soaked in a bichloride solution, or with little ash bags, one or two larger bags being placed over all. Firm pressure is then made with a roller bandage. After eight or ten days the dressing is removed and a second one applied, if necessary. Disturbance of the wound by flexion of the thigh is prevented by a short splint extending from the anterior superior spine of the ilium to the middle third of the thigh. Where an ulcer has already formed, the infiltrated parts are removed by the scissors and the sharp spoon, and the cavity is filled with sand wet with a solution of the bichloride, and covered with a few layers of gauze. Should the discharge be sufficient to saturate the outside dressing, this is removed and fresh gauze applied. The sand, however, is not removed, but is wet again with the solution. Dr. Kümmell claims excellent results in the treatment of bubo by this method. In cases where the skin is still sound, he says that union by first intention is usually obtained, and where ulceration has occurred, the wound heals rapidly by granulation with a very moderate amount of suppuration.—*Centralblatt für Chirurgie.*—*Med. Record.*

#### DISEASES OF THE SKIN.

**Differential Diagnosis between Lepra, Lupus and Cancer, as they Effect the Throat.**

1. Lepra is always apparent on the skin, before the throat gives any manifestation of its presence.

Either lupus or cancer may sometimes exist without giving rise to any cutaneous affection.

2. Lepra always announces its onset by a reddish discoloration, which gradually disappears and is succeeded by paleness without tumefaction.

Lupus is developed on the mucous membrane without any morbid alteration in the latter.

Cancer commences by congestion, swelling, and slight pain in the region affected.

3. The tubercles of lepra are white, soft, and of variable size. They form a chain resembling a string of beads. Their sensibility may be normal, diminished, or completely abolished.

The tubercles of lupus are pinkish or red, hard, resisting and elastic. They are larger than those of lepra, few in number, scattered, and generally indolent.

The tubercles of cancer are red or grayish. They are either hard or soft, and are troublesome by reason of the pain they occasion.

4. There is well-marked tumefaction of the mucous membrane in lepra; in cancer, a hard œdematous swelling. The tubercles of lupus are seated on a structure which retains its normal condition.

5. The ulcers of lepra are soft, somewhat resembling syphilitic mucous patches; in some cases they are insensible. In lupus the borders of the ulcers are hardened and elevated; their bases constricted, sinuous, and without odor.

The ulcers of cancer are large, with irregular bases, and are covered and surrounded by papillary growths. Usually, they are exceedingly painful.

6. The cicatrices of lepra and those of lupus are very similar in appearance and consistence. They differ in that the cicatrices of lepra are insensible,

while those of lupus preserve a degree of sensibility corresponding to that of the surface which they occupy. In cancer there is no cicatrization—either complete, partial or temporary.—Dr. DE LA SOTAY LASTRA, *Rev. de Laryngol., d'Otolog., et de Rhinol.*—*Ibid.*

#### Ichthyol.

UNNA and SCHROETER speak in high terms of this remedy in eczema. Ichthyol is a carefully prepared product obtained from the destructive distillation of bituminous rocks and stones. At first it was tried in strengths varying from two to ten per cent. with unguents, as zinc benzoate. Thirty cases of eczema of different varieties were treated with the ichthyol, and with happy results. Stronger ointments were tried, up to as much as fifty per cent. The following mixture is recommended: Lithargyri, 10; cog. c. aceti, 30; ol. olivae, adips., āā 10; ichthyoli, 10. M. ft. Ung.

It may also be combined with the preparations of mercury. It has been used with success in acne rosacea. One case of favus covering the entire head, was brought to a healthy condition in three weeks by the ichthyol spray and ichthyol vaseline.

In a case of severe psoriasis, the left arm was treated with chrysophanic acid; the right with ichthyol. The left made so much more progress than the right, that both were soon put under the acid.—*Monat. für Prak. Dermatol.*—*Ibid.*

#### Treatment of Ringworm of the Scalp.

Dr. TOM ROBINSON writes as follows concerning the treatment of this usually very intractable affection: "In ringworm of the scalp I always refuse to treat the case unless the child has the head shaved, believing it to

be impossible to bring any remedy into contact with the fungus unless this be done. I then direct the scalp to be well washed with a liquid made by dissolving one drachm of the Pharmacopœia soft soap and half a drachm of carbonate of potash in twelve ounces of orange-flower water. After this is done I direct my patient to wear a piece of lint covered with oil-skin continually for a week, which lint is saturated every two hours with the following solution: Hydrarg bichloridi, gr. vi.; acidi carbonici, 3 i.; sp. vini rect., 3 vi.; glycerine, 3 vi.; aquæ, ad 3 xi. Misce. After this has been earnestly carried out, I am sure the disease will but in a few instances give further trouble. The rings will probably be scaly for some time afterward; but if the head is kept clean and the nitric oxide of mercury ointment of the Pharmacopœia used at intervals the normal appearance will be resumed."—*Can. Med. and Surg. Jour.*

#### Lotions Applied to the Hairy Scalp,

Especially where the hair is thick and long, seldom accomplish the good desired, on account of failure to reach the scalp. Under such circumstances Dr. L. DUNCAN BUCKLEY (*Journal of Cutaneous and Venereal Diseases*) suggests the use of the ordinary glass medicine dropper or the instrument used for filling the stylographic pen. The lotion is drawn up into the tube and the point is inserted under the hair, and by this means the fluid is thoroughly applied. One hand holds the dropper and the other is used to rub the lotion into the scalp. Many who have used this plan have been greatly pleased with it.—*Chic. Med. Rev.*

#### Boracic Acid

May be readily reduced to a powder by the following process: First warm a

Wedgwood mortar by pouring into it a little alcohol and setting fire to it. Then put into the warm mortar the boracic acid with a few drops of glycerine, when it will be found easily reduced to as fine a powder as desired.—*Ibid.*

### DISEASES OF THE EYE AND EAR.

#### The Action of Quinine on the Ear.

Dr. J. ORNE GREEN thus concludes a paper on this subject in the *Boston Med. and Surg. Jour.*: 1. Clinical experience the world over is that quinine occasionally produces serious injury to the ears. 2. From our present knowledge, both clinical and experimental, we are justified in asserting that the action of quinine upon the ears is to produce congestion of the labyrinth and tympanum, and sometimes distinct inflammation, with permanent tissue changes. 3. That the action of the drug upon the ears should always be considered in prescribing it, and changes in the ears, due to existing or previous inflammation of those organs, constitute a contra-indication to the medicine in large doses or for a long time except under urgent circumstances. 4. That where large and continuous doses are absolutely necessary an occasional intermission of the administration is desirable, if possible, to diminish the risks to the ears.—*Med. and Surg. Reporter.*

#### Jequiritic Ophthalmia.

WECKER (*Ann d'Oc.*) has employed jequirity in a large number of cases of obstinate granular conjunctivitis, and draws the following conclusions: 1. Lotions of infusions of jequirity seeds produce a purulent ophthalmia of croupous nature, the intensity of which can be regulated by the number of lotions which are employed, and by the strength

of the infusion employed. 2. The cornea runs no risk during the evolution of the jequiritic ophthalmia. In only a single case, in which the ophthalmia was pushed to a veritable diphtheritic aspect, was there produced a circumscribed and transient desquamation of the cornea. 3. The jequiritic ophthalmia rapidly cures the granulations, and, even if reproduced several times, it acts with much less danger and discomfort to the patient than inoculation, for it always disappears, without any treatment, by confining the patient for from eight to twelve days in a darkened room.—*New York Medical Journal*.

#### Effects of Agents Introduced Into the Ear.

BROWN-SÉQUARD announced not long ago that the introduction of a few drops of chloroform into a guinea-pig's ear causes death by meningo-encephalitis. Vulpian has more recently shown that the introduction of hydrate of chloral into a rabbit's ear causes extensive muco-purulent bronchial effusion, lasting for several hours, which may cause death. Small doses, which do not give serious symptoms at the time, are sometimes followed by vertigo, lasting for a month or more. The application of these facts to the local treatment of earache or neuralgia by instillation of chloroform, ether, creasote, etc., is very evident.—*Acad. des Sciences*.

#### The Mechanism of Lachrymal Conduction.

In a monograph entitled "Die Muskulatur der Thränenwege und der Augenlider," published in Stuttgart, Dr. G. KREHBIEL, of New York, embodies the results of a painstaking anatomical study of the lachrymal apparatus. He states that the tensor tarsi muscle arises by two roots, the anterior and inner root from the crest of the lachrymal bone, the other behind and external to the

first. Immediately after their origin the fibres of the two roots become interwoven, enclosing in their meshes the canaliculi and the ducts of the Meibomian glands. Thus the tarsal portion of the orbicularis muscle is formed of intermingled fibres from both roots of Homer's muscle, but those from the inner root run mostly along the lower lid, and the others along the upper. The author thinks that the tensor tarsi should be regarded as a muscle distinct from the obicularis. When in action it exerts a considerable compressing force upon the canaliculi, and in so doing occasions the normal periodical emptying of these tubes. It has nothing to do, however, with the expulsion of the contents of the lachrymal sac. The latter is covered on its lateral wall, for the most part, by an aponeurosis from which arise fibres of the orbicularis palpebrarum. The contraction of these fibres causes a widening of the lachrymal sac. Thus, at every closure of the lids, two synchronous actions are caused. The lachrymal sac is dilated by the fibres of the orbicularis, and the canaliculi are compressed by the tensor tarsi. The emptying of the lachrymal sac is occasioned by atmospheric pressure, which exerts its influence the moment the eyes are opened and the orbicularis is relaxed. When the eyes are open the canaliculi act like capillary tubes to suck in the tears. If an unirritating colored fluid be dropped into the outer corner of the eye and winking be restrained, its presence in the nasal cavity is very quickly made manifest.—*Med. Record*.

#### DIGESTIVE TRACT.

##### Iodoform as a Local Application in Fis- sure of the Anus.

Dr. THOMAS HAY (*Med. and Surg. Reporter*). In the treatment with this

remedy, the alvine evacuations should always be maintained in a soft condition; the bowels should never be allowed to become constipated or relaxed; the anus, and parts involved by the fissure, should be kept constantly clean and free from deposit and dry incrustations; and with one or two evacuations a day, the case may be speedily cured by the local use of iodoform. It may be dusted, in *very fine* powder, upon and into the fissured parts, or applied in the form of ointment or suppository. The application of the simple powders, if properly prepared, three or four times a day, after each evacuation, and in the intervals, is often sufficient. In some cases, however, the undiluted powder—although thoroughly powdered—causes some pain. In such, the iodoform may be mixed with powdered gum acacia, if a powder be preferred, or may be made into an ointment with vaseline, or suppository with the oil of theobroma. Balsam of Peru, carbolic acid, and oil of peppermint, will moderate the intensity of the iodoform odor; but this can hardly be requisite for application in this situation. The application of the remedy may be followed by a little smarting, but soon after its use the sensibility of the parts becomes benumbed, and even defecation may go on without consciousness, so far as concerns the development of pain during or after the process. That this remedy applied as above directed and indicated will cause complete unconsciousness of the act of defecation, I doubt—I have never witnessed such result in any case that has come under my notice, and still the benumbing influence of the remedy is decidedly potent. As in applications to the conjunctival surfaces of the eyelids, the first and most important factor in the successful and painless use of the remedy consists in the proper preparation of the powder.

It should be made *very fine*, and not the smallest crystal be allowed to remain unpowdered. The neglect of this precaution when applied to the eye has caused the most painful inflammation of the ocular and palpebral conjunctiva; and applied thus imperfectly powdered to the anus, would likewise cause intense suffering, and as in eye practice, would be abandoned, and declared to be dangerous and valueless, if intelligence did not bring relief.

#### External Hemorrhoids.

According to the *Drug Cir.*, Dr. BLASCHO, of Berlin, recommends compresses soaked in a one per cent. solution of ergotin to be applied hourly. D. Pasqua, of Florence, gives the following ointment as infallible: Extract of belladonna, gr. v.; iodoform, acetate of lead,  $\bar{a}\bar{a}$  gr. j.; petroleum jelly,  $\bar{z}$  j. Make into an ointment, to be applied three or four times a day.—*Ibid.*

#### Distention of the Stomach by Carbonic Acid Gas as an Aid in Diagnosis.

The more frequent employment of this long-recognized method is advocated by Dr. ROSENBAACH as a means of determining more definitely the situation and character of tumors of the stomach and neighboring abdominal organs. He claims that we can by this means ascertain exactly the position of the stomach, and can determine the size and location of tumors of this organ. The borders of the liver and the gall-bladder are rendered more distinct. Tumors of the spleen can be more readily diagnosed and differentiated from those of the kidney. And lastly, we can study better the pulsating painful tumors met with at times in the abdomen. The author states that such tumor is, in most cases, the head of the pancreas pushed forward by the dilated aorta. When the stomach is distended the tumor disappears, showing that it lies behind this organ.—*Schmidt's Jahrbücher. — Med. Record.*

## FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

### On the Treatment of Certain Fractures of the Lower end of the Femur.

Mr. F. TREVES (*Brit. Med. Jour.*) records three important cases in which he has practiced division of the tendo Achillis as a primary step in the treatment of fracture of the lower end of the femur. It is in relation to this class of fractures that Bryant says: In fractures of the lower third, above the condyles, where the gastrocnemii muscles tend to draw the lower fragments backward into the popliteal space, some surgeons prefer the use of the inclined plane, and, where the bones cannot be otherwise kept in apposition, it is, probably, a sound practice. But what I believe will turn out to be a better one is the division of the tendo Achillis and the use of the long splint. \* \* \* I have taught this for the last twelve years, but have had only one opportunity for testing its value.

The fractures referred to are generally either just above the condyles, or are through the shaft just above that point. The fracture may be transverse or oblique; usually, however, of the latter variety; and the obliquity is apt to be extreme, with its general direction from behind downward and forward. The position of the upper fragment is practically unaffected, while the upper end of the lower fragment is drawn forcibly backward into the popliteal space by the action of the gastrocnemii muscles. The lower fragment is also drawn upward, and, from the twofold displacement, it follows that it may cross the axis of the upper fragment at a considerable angle while it lies behind that portion of bone. These fractures are often associated with secondary vertical ones through the condyles into the joint.

All fractures in this part are not attended by this deformity, and the treatment referred to is only recommended for those in which the lower fragment is forcibly drawn into the popliteal space by the gastrocnemii. It is obvious that these cases cannot be treated in the ordinary way. Extension in the long axis of the limb merely increases the deformity by dragging upon the gastrocnemius and the lower fragment. In this way, with a long splint it would be possible for the limb to be put up apparently straight while the knee-joint was in reality considerably flexed. It is useless to try and act upon the small lower fragments by pads and pressure, and, therefore, the long splint has been pretty generally abandoned in favor of the only other available treatment, viz., by some form of the double-inclined plane. By this the knee is bent and the large upper fragment is brought to the lower one; the parts can be well fixed to the splints, and the weight of the trunk is made use of as an extending force. In applying this treatment, the actual double-inclined plane is seldom made use of, but some modification of it, as MacIntyre's splint bent at the knee and slung from a cradle, Nathan Smith's anterior wire splint, Hodgen's suspension splint, and the like; in all of which the knee is bent, the parts below the fracture are practically fixed, and the weight of the body acts as an extending force. The objections to this form of treatment are found in the fact that the patient's body and the parts above the fracture are not fixed, and an undue freedom of motion in the upper fragment is possible; and also that the joint is fixed in a flexed position, and is liable to become ankylosed so. By section of the tendon, any deformity produced by the gastrocnemii muscles may be entirely removed, and the fracture may be treated with all

those advantages which pertain to the long splint.

The author's three cases are related in full, and in two of them the local result was examined and noted post mortem.—*N. Y. Med. Journal*.

#### Fracture of the Shaft of the Thigh Bone.

Clinical lecture by JOHN ASHURST (*Columbus Medical Journal*): This man has a form of injury of which we see a large number of examples in this hospital. He has a fracture of the shaft of the thigh bone. When admitted there was three-fourths of an inch shortening, marked bowing of the bone outwards and crepitus. He has been under treatment for ten days and is doing well.

One of the common symptoms of fracture of the femur is in this man, not as marked as it is sometimes, that is, effusion into the knee-joint. There is a little effusion here; I find that the patella floats, and that I can press it down, but as soon as I remove my finger, it rebounds. This symptom is almost universally present in fracture of the thigh bone. The explanation of this has been given by Gosselin. The blood effused in the neighborhood of the fracture makes its way downward until it reaches the exterior of the synovial membrane, and by irritation of its external surface produces a positive sub-acute synovitis, followed by effusion into the joint. The swelling subsides spontaneously in the course of a week or ten days, and is, as a rule, a matter of no consequence. It is, however, important that you should know that it is a symptom of fracture, for otherwise, it might give rise to the suspicion that the joint had been injured. It has another bearing of some importance as regards the particular mode of dressing. Many surgeons

directed to the seat of fracture and then surround the limb with a circular strip above the knee. If a limb is dressed in this way with the knee covered in, and swelling occurs, it causes pain, and it becomes necessary to remove the dressing. It is unnecessary to carry the extending bands above the knee, for it is a mistake to say that the ligaments of the knee can be stretched by any force which we can apply. No force applied to the skin can specially affect the ligaments.

In regard to the amount of weight, I think that you will generally find two, or at the most, three bricks sufficient. A brick is estimated to weigh four pounds and a half. We begin with one brick. This steadies the limb and prevents spasm; afterwards, we add a second brick and perhaps a third. Some surgeons use very heavy weights, as high as twenty and thirty pounds or even more. There is some risk of producing non-union by such powerful extension. I consider shortening an unavoidable result of fracture of the femur in adults. The union of the fragments of a broken bone may be roughly illustrated by a piece of broken sealing wax. If you wish to unite the two pieces, it can only be done at the expense of the wax itself. In a broken bone the fragments unite by the formation of granulation tissue, cartilaginous callus develops and finally bone is formed; so that a little shortening is inevitable in an adult, though it may be very slight in children, there may be an increased length of the limb. This is not due to a separation of the fragments nor to a stretching of the ligaments, but owing to the irritation there is developed, to an excessive degree, the osteogenetic function of the so-called cartilages of conjunction, and there is an increased production of bone. As far as the fracture is concerned, there has been shortening, but this is more

than compensated for by the increased production of bone.

In order to keep a fractured bone at rest, it is necessary to fix both the joint above and below. When a joint is affected you fix the bone above and below. In fracture of the thigh, the knee-joint should be fixed, and, if possible, the hip-joint. I think that this can be best accomplished by the use of the long-splint of Liston, or that of Desault as modified by Physick, with the foot-piece removed.

We have here a long splint extending from the axilla to just below the foot, and a short splint extending from the groin to the inner malleolus. The splints are wrapped in a splint-cloth, and between them and the limb are placed these bags filled with bran and known as junk-bags. Many explanations have been given as to the exact derivation of this term "junk" bags. One is that it is obtained from the French word "jonc," which means a reed, from the idea that the older surgeons used reeds in the treatment of fractures. Another explanation is that it is a corruption of the term junction or joining bag. Whatever may be the correct explanation, the fact is, from time immemorial they have been called junk-bags. I prefer the use of the long splints and junk-bags to the use of sand bags, where there is a fracture in the shaft of the bone, for I think that they give a better lateral support. There is always a tendency in this injury to an outward bowing, and I have seen this deformity quite marked after the use of the sand bags. In fractures of the neck of the bone, sand bags will answer very well. This tendency to bring outwards may also be in part overcome by keeping the limb in a state of abduction. The splints are kept in position by means of five strips of bandage; one at the ankle, one at the knee, one as high in the crotch as it is possible

to get it, one around the pelvis and another at the upper extremity of the long splint.

#### A New Feature in the Treatment of Fracture of the Clavicle.

Dr. S. J. ALLEN (*Jour. Mat. Med.*): The most important, and still the most difficult thing to accomplish in the treatment of fracture of the clavicle, is to prevent displacement of the broken ends of the bone, or, in other words, to secure union without deformity.

The following described mode of treating this fracture has, in my experience, been successful in this particular, or, in other words, ensuring union without deformity:

Cut a piece of Seabury & Johnson's adhesive plaster two and a half inches wide and eighteen inches long. Fold the strip, plaster side out, so as to make a compress of equal width and length. Place the compress on the fractured part. The heat of the skin will make it adhere. Then cut the two other pieces of the plaster three inches wide and two feet long, longer or shorter, according to the size of the person under treatment. First apply one of these strips, commencing on the front part of the chest, so that the portion that goes over the shoulder shall be equi-distant from each end, and continuing it down the back, drawing it tight enough to compress the tilted fragments to a level, or, in other words, to bring the broken fragments together. Then apply the other strip in the same manner, but in such relation to the first so it shall cross it obliquely directly over the compress. These strips and the compress will generally remain in place long enough to secure consolidation of the fracture.

This simple appliance, with the figure 8 bandage and a sling for the corresponding arm, is all that will be required,

or, I may say, has been required in my practice, to insure a perfect result, or, in other words, union without deformity.

The only new or original feature of this dressing is the construction of the compress adhesive plaster, plaster side out, so as to prevent its slipping or becoming in the least displaced; and this I do not know to be new, but so far as I have read, heard or seen, it is a new feature in the treatment of this fracture. At any rate, all will admit that union of this fracture without deformity has always been the *exception*, not the *rule*, when treated with the greatest care and painstaking by either of the methods heretofore practised.

About one in five of these fractures occur in the female, and she at least will thank the surgeon if he uses this compress as a feature in his dressing.

#### **A Case of Reduction of a Dislocation of the Hip by Incision into the Capsular Ligament.**

Dr. POLAILLON (*Bull. gén. de Thérapeutique*) records a case of this exceedingly rare surgical procedure, and states that it is the third attempt of the kind on record, the first one being by Volkmann in 1876 ("Berlin. klin. Woch.," No. 25, p. 357, 1877), and the second by MacCormac in 1878. In both of these cases reduction failed, and the operation was completed by resection of the upper end of the femur, the patients recovering. In the author's case reduction was accomplished, but the patient died of gangrene. The case was an exceedingly poor one for surgical interference, the man being a drunkard, with the usual visceral changes caused by alcohol.

The operation was performed antiseptically. The cutaneous incision was 10 cm. long, starting from the anterior in-

ferior spine. The muscles and fascia were incised to the same extent, thus exposing the joint. The great trochanter was found to be fixed against the cotyloid cavity, the upper border of which was masked by a thick layer of fibrous tissue, which extended from the upper border of the neck of the femur to the superior border of the cotyloid notch. This anterior thickened portion of the capsular ligament (the Y-ligament) was divided with the knife, and the finger could be passed between the neck of the femur and the cotyloid cavity, which was free. In spite of this division, an attempt at reduction by manipulation failed, and it was necessary to divide the muscles in front of the joint at their insertion. Further manipulation then brought the head of the bone out of the foramen ovale into a position over the cotyloid cavity, and thence the reduction was accomplished. No artery was wounded during the operation, which lasted three quarters of an hour, and the wound was dressed antiseptically. Four days after, the patient succumbed to a gangrenous inflammation of the deep femoral region. On autopsy, the head of the femur was found in the acetabulum. The author thinks that, in consideration of the patient's bad general condition, the death could not properly be attributed to the surgical interference, the operation being neither very long nor very severe.

Volkmann made in his case a long longitudinal incision, starting from the crest of the ilium and passing over the great trochanter. MacCormac made a Y-shaped incision, involving a great part of the femoral region.—*N. Y. Med. Journal.*

#### **Perforated Felt Jacket in Spinal Curvature.**

A case at present under treatment, illustrates some of the advantages to be

derived from the use of these jackets, combined with muscular exercise. The patient, a female child, aged 11, came under my care in August, 1882, suffering from considerable excurvation in the dorsal region, for which she was wearing, at the time, a steel spinal support with arm crutches, by which her shoulders were being pushed almost up to her ears. A perforated felt jacket was made for me by Mr. Rorke, of North street, Fitzroy square, and instructions were given that she should exercise with the trapeze several times a day for a quarter of an hour at a time. Already in five months a decided improvement has taken place. The prominence in the back has diminished in size and elevation by half an inch, the shoulders are no longer pushed up to the ears, and the whole body has grown. The child can move her limbs with the greatest freedom, and much prefers the jacket to any instrument she has worn. Thus, in a most unpromising case, no resort to the surgical instrument maker is required beyond the first manufacture of the jacket, which can be softened and reapplied by the surgeon as often as necessary, and which is taken off by the mother once a fortnight for purposes of cleanliness, while necessary exercise is not interfered with. I notice that in a recent pamphlet by Mr. Noble Smith, felt jackets are spoken slightly of, and their porosity in particular is declared to be "a myth." However true this may be of the material originally used for these jackets, it is, I believe, a mistake in regard to the perforated felt, in which the pores are good sized holes perfectly visible to the naked eye. For efficiency, lightness and cheapness, these jackets leave, I venture to think, little to be desired.—H. N. HARDY, F.R.C.S.E., *Brit. Med. Jour.*

#### Hernia Reduced by Electricity.

The *Practitioner* says that Dr. SUPRUNENKO mentions an experience of interest in the *Wratsch* (No. 17, 1882). A right inguinal hernia, strangulated for three hours, had resisted half an hour's taxis. A moderately strong induction current was then tried, the positive electrode being pressed against the tumor, while the negative was applied first against the lumbar vertebrae, afterwards over the umbilicus. The hernia at once began to diminish, and in less than two minutes disappeared entirely. Another case is given in the same journal (No. 40, 1882). An old man of eighty had suffered from a strangulated hernia for twelve hours. Persistent taxis had altogether failed, though Dr. Pergamin kept it up for over two hours. The induction current was then used for fifteen minutes, the pole being applied to various parts of the tumor, but this also failed. The current being still maintained, he again attempted manipulation, and in two minutes the bowel returned into the abdomen with a gurgling noise.—*Centralb. f. Chirurgie.*

#### Umbilical Hernia of a Part of the Stomach Wall.

A boy, thirteen years of age, had a tumor, about the size of a walnut and of a bright red color, at the navel. It was covered with mucous membrane, which secreted, upon being handled, a viscid fluid of acid reaction. The tumor, which was attached to the umbilical ring by a slender pedicle, remained always of the same size and was irreducible. No opening into the interior could be discovered. The mother stated that the cord had been of great thickness, and, near the navel, was funnel-shaped. It was ligated very close to the body. When the end came away the tumor was noticed. There had never been

any food or fecal matters discharged from the navel, nor did the secreted mucus ever have a fecal odor. The pedicle was cut through, and the wound rapidly cicatrized. Dr. TILLMANN, who reported the case (*Centralblatt für Chirurgie*, March 3, 1883) believed it to be an ectopia ventriculi. He stated that the secretion possessed the power to digest fibrin, and, further, the microscopical examination of the tumor showed it to be composed of gastric mucous membrane from the neighborhood of the pylorus. The portion of prolapsed stomach was cut off with the umbilical cord, this little piece being at the distal end. The opening into the stomach was closed probably at the time of birth.—*Med. Record*.

#### Femoral Hernia.

A very unusual accident happening in a case of large femoral hernia is reported in the London *Lancet* by Mr. BERNARD PITTS. A woman, forty-six years of age, had suffered from a right femoral hernia for twenty years. In 1880 she had for three days symptoms of strangulation, but was relieved by an operation, the hernia at the time being about the size of two fists. After this, for about a year, she was enabled to keep up the bowel by the use of a truss, but subsequently the hernia increased so much in size as to render the truss useless, so that she left it off entirely. One night last December, while going up stairs, she was seized with a paroxysm of sneezing, and felt something suddenly give away in her right groin. She became faint, but succeeded in reaching her room, when, on examination, she found about a foot of intestine protruding through a rent in the coverings of the hernia. Failing to reduce it, she sent for a physician, who tried taxis for a short time, but without success. She was

then sent to the hospital suffering from severe shock. An examination under ether showed that one foot and a half of small intestine had escaped through a rent in the skin, about an inch long, a little above the cicatrix left from the former operation. The exposed intestine was bruised, congested, dirty, and very cold, with a number of hairs and foreign particles upon it. The bowel and mesentery were carefully cleansed by warm carbolic lotion, and an effort made to return it, which failed. The opening in the skin was then enlarged freely, when a large quantity of small intestine, about four or five feet, together with the cæcum, escaped. A slight enlargement of the crural ring was then made with the hernia knife, and by patient manipulation the intestines were returned to the abdominal cavity. A sponge was placed on the opening, and the sac, which was very much thickened, was dissected from its surroundings and removed, necessitating the tying of many small vessels. The sponge was then removed and the cut edges of the sac brought together by stout catgut. A large portion of redundant skin was then removed and the edges of the wound brought together by silk sutures, and carbolic gauze placed over it. The next morning the temperature was 100.4°, but rose during the day to 102.4°, the breathing became labored, and the pulse increased to 132. She was better, however, the next day, the temperature falling to normal, and never afterwards rose above 100°. She made a slow recovery and wears a truss. In his remarks following the account of the case, Mr. Pitts says: I believe that, by getting rid of a large sac and redundant skin, the chances of continued suppuration are much lessened, and, where there is a large hernia opening, the ligature of the neck of the sac diminishes the dan-

ger of inflammatory extension from the wound to the peritoneal cavity.—*Weekly Med. Review.*

#### Hemorrhage from the Rectum—Its Causes and Treatment.

Dr. J. M. MATTHEWS (*Med. Herald*).

The causes of hemorrhage from the rectum may be briefly named as follows: 1. Hemorrhage following the ligation of internal piles. 2. From ulceration of the bowel. 3. From capillary hemorrhoids. 4. From hemorrhagic diathesis. 5. From polypi. These in my opinion constitute the only causes of hemorrhage requiring surgical interference. The existence of piles in all classes is recognized. The operation for their relief is often attended with much bleeding. True, that surgeons do the operation thousands of times without such an occurrence, yet so able a surgeon as Sir Astley Cooper lost a patient from hemorrhage after the ligating of a pile. There are three causes for hemorrhage following this operation, viz.: 1. The division of a vessel or vessels at the time of operating. 2. Puncture of a vessel in transfixing tumor. 3. In sloughing of the pile.

The hemorrhage that takes place after ligating the tumors may be accidental, recurrent or secondary. Primary hemorrhage is rare. It has been my experience that it is seldom necessary to apply a ligature for its arrest. Indeed, I have never had occasion to do so in my practice. If a general oozing takes place, say after the recovery from shock, it can usually be arrested either by pressure or the application of hot water. If cold is used the reaction will sometimes prove dangerous. I am sure that hot water acts as a stimulant to both the walls of the vessels and to the nerve fibriles in the wound. One advantage in its use is that it does not produce

shock. That it is a valuable hemostatic cannot be doubted. The styptic solutions of iron cannot be used in these cases because they destroy the ligatures that have been applied to the piles.

#### *Puncture of a vessel in transfixion.*—

In the method advocated by Dr. Van Buren of New York, of transfixing these tumors, much bleeding may occur from the piercing of a blood-vessel by the needle. The only remedy in such event would be to draw down the pile and place a ligature above the point of bleeding.

*Hemorrhage from sloughing of the tumors.*—This is seldom met with if the operation is by the ligature. It has been the misfortune of the writer to see several severe cases of the kind following the operation of injecting piles with carbolic acid. In hemorrhages from sloughing, it is out of the question to attempt to apply the ligature. Recourse must be immediately had to plugging the rectum. This is best done by taking a bell-shaped sponge and threading it through the apex with a stout string, wet it in water and powder with the persulp. iron; push it gradually and steadily up the rectum, and pull upon the string; this expands the sponge and causes equal pressure. In lieu of this arrangement, cotton wool can be treated in like manner and placed in position through a speculum.

*Hemorrhage from ulceration of the bowel.*—I use the term ulceration here, believing that it is an ill term and should not be used in this connection, yet the authors have failed to give us a better one. True, ulceration is not and cannot be accompanied with much bleeding, for the reason that there is sufficient inflammatory action incident to the disease to clog the vessels, hence to prevent hemorrhage.

The condition to which I desire to

direct your attention, in contradistinction to ulceration, is an abrasion sometimes found in the epithelium of the gut. This may arise from trivial causes, as the passage of hard fecal matter, etc. The result may cause serious alarm. There is no inflammation attending this "peeling" off. In its incipency, the blood pours freely from the capillary structures unless active measures are taken to suppress it. The discharge may be pure blood, or blood mixed with the mucous of the bowel. Very many of these cases have, I am sure, been mistaken for other affections, notably dysentery.

*Treatment.*—The object of treatment in cases of this nature is of course to produce sufficient inflammatory action to clog the vessels with lymph. The very best application to accomplish this is in my opinion pure carbolic acid. It should be applied not only to the abrasion proper, but to the mucous membrane surrounding it. It stops hemorrhage and does not destroy the membrane. Nitric acid, or the acid nitrate of mercury, would likely accomplish the same purpose, but at the risk of producing stricture. It would be inconvenient to apply the actual cautery. Very little account of the affection of which I am speaking is given in the works on surgery, or in the books devoted to diseases of the rectum; unique they may not be, but certainly demand more attention than they receive.

*Hemorrhage from capillary piles.*—It will be remembered that these are the small, spongy, raspberry-looking pile which is often met with. Its disposition is to bleed upon the slightest provocation. The blood lost is usually pure arterial. A hard stool, or straining at stool, is common cause of a rupture, and the amount of blood sometimes lost is enormous and may end fatally.

*Treatment.*—In my opinion it is best, in order to arrest the bleeding, to catch up the entire spongy mass and secure it by a silk ligature. The ordinary tenaculum forceps used in ligating piles are objectionable in these cases. They tear through the mass and cause fresh bleeding, besides they do not enable you to secure the mass with ease. I have devised a forceps which is made by Adolph Fischer of this city, which answers the purpose better. It has a serrated edge, instead of forks, and placed on the handle at an angle of about forty-five degrees. In many cases I have stopped the bleeding by the application of pure nitric or carbolic acid. The actual cautery here is a most excellent remedy. The thermo-cautery is the form in which it should be used.

*Hemorrhage from a hemorrhagic diathesis.*—This as a cause for hemorrhage from the rectum is scarcely mentioned by the authors. That it occurs, has been evidenced in my practice, and when met with is of the most serious nature. Local measures seem to do but little good, and it is to be questioned if such patients are ever relieved. The diathesis is manifested in the rectum, as it would be in any other, or all portions of the body. The slightest scratch, or abrasion, or handling the part is sufficient cause for the hemorrhage, which is often uncontrollable.

*Treatment.*—This diathesis may be hereditary or it may be established by habit. Sedentary life conduces much to its production. The habits should be diligently inquired into, and a change, if necessary, positively enjoined. Exercise, fresh air, proper diet, etc., should be carefully looked after. The sheet-anchor, in the treatment, I believe to be ergot or ergotin. This should be combined with iron and given for its full effect. The best local applications are,

hot water (injected), subslup. iron, and pure carbolic acid. Each repeated as often as the case requires. The last cause which I have named for hemorrhage from the rectum calling for surgical interference are polypi. These tumors may lie above the sphincter muscles for a long time, giving no special inconvenience, but all at once they may begin to bleed, either from detachment or other causes. They are very vascular and fed by a good-sized vessel. They should be brought into view and the pedicle ligated. This is best done under an anæsthetic, and by dilating the sphincter forcibly. If hemorrhage should occur from the sloughing of the tumor, or from its being torn off, the pedicle, or stump, must be sought, and if it is not possible to include it in a ligature, the rectum should be plugged in the manner herein described.

#### VENEREAL DISEASES.

##### Six Years' Experience In the Treatment of Syphilis.

DR. CHARLES R. DRYSDALE thus concludes an article on this subject in the *Med. Press*: The treatment of syphilis, commencing with the initial lesion, ought to be continuous, and should consist of very small doses of some mercurial salt, continued for months. When severe symptoms are seen, inunction, calomel vapor baths, or fractional doses of the mercurial salt should be given for a week or so every four hours, in combination with large doses of the iodide of potassium, sodium, or ammonium. Atropia drops should be frequently used in iritis. In gummy deposits the chief curative remedy is iodide of potassium in large doses; but a tonic dose of some form of mercurial salt may be added as a germicide. If cerebral symptoms supervene,

they are to be treated energetically with the iodide and with immersion.

Mercury in such small doses seems to do no harm to the general health, and there is much evidence to show that it is a tonic, which may be given even for years with advantage in some cases of anæmia. All cases of syphilis, mild or severe, should be treated by these small doses of mercury in order to prevent the supervention of tertiary symptoms or gummy products. The germ of syphilis has not yet been seen by the microscope, but it exists in all probability, and this is the rational account of the useful action of mercury and iodine, which are both germicides.—*Med. and Surg. Reporter.*

##### Treatment of Syphilis Complicated with Malaria.

Malaria is not, perhaps, a frequent complication of syphilis in this country, but the treatment employed in such cases by SIGMUND will, without any doubt, prove applicable in many cases occurring in our large cities, where the individuals are, to use a common expression, considerably run down.

The essentials of treatment are as follows: 1. Each morning rub into the groins or elsewhere five grams of mercurial ointment. 2. At bedtime the patient will take two pills, prepared according to the following prescription:  $\mathcal{R}$  Ac. arsenious, gr. ij.; ferri protochlorid, gr. xv.; quiniæ sulph., gr. xlv.; ext. gentianæ, q. s. Et. ft. pil. No. 100 of three grains each. Augment progressively the dose from two to six pills.—*Ibid.*

##### Immunity of Animals from Syphilitic Inoculation.

Professor NEUMANN has made a number of attempts to inoculate animals with syphilis, but without success. The experiments were made with the greatest

care, the virus being taken directly from the diseased person and introduced into the body of the animal. The animals experimented upon were kept under observation for a considerable period of time after the inoculation. In no case did any results obtain other than those which would naturally follow the introduction of an irritating material into the tissues. Nothing that bore any resemblance to a chancrous tumor was observed. The animals employed in these experiments were three apes, three rabbits, a horse, a hare, a white rat, a marten, and a cat. The total number of inoculations was fifty-four. Neumann concludes from these experiments that we must regard syphilis as distinctly a disease of man.—*Med. Central-Zeitung*.—*Med. Record*.

#### A New Remedy.

A new remedy in the treatment of syphilis is described by Dr. J. MARION SIMS in *The British Medical Journal*. It consists of fluid extracts of smilax sarsaparilla, stillingia sylvatica, lappa minor, phytolacca decandra, and a tincture of Xanthoxylum carolinianum. The s. sylvatica (queen's delight) is thought to be the active drug. It has long been used in the South against syphilis by the Indians and negroes. It has also been introduced and used by Drs. McDade and Rush Jones. Some remarkable instances of its efficacy are given by Dr. Sims.

#### Excision of the Chancre.

The following conclusions are reached by SPELLMAN with reference to excision of the chancre for the prevention of subsequent lesions (*Annales de Derm. et de Syph*): 1. When excision has been apparently successful it does not necessarily follow that the operation had an abortive affect, since in many cases a

chancre, *i. e.*, an apparently specific sore, is not followed by secondary symptoms. 2. Excision is not dangerous, especially if antiseptics be used; the wound heals readily. 3. It may be difficult or unadvisable when it would mutilate some organ. 4. It may have no effect on the subsequent course of the syphilis. 5. It is held by some that excision makes syphilis less severe, the chancre being by these regarded as a syphilitic headquarters.

Of course, to be of any use, excision should be made before implication of the glands.—*Weekly Med. Review*.

#### Chancre on the Chin.

In the *Jour. Cut. and Ven Dis.*, Dr. MORROW relates the case of a man in whom there was an indurated crateriform typical chancre on the front of the chin, just below the free border of the lips, which had been there for three weeks. The patient ascribed it to a cut from a razor in a barber shop. He has now a general roseola (the chancre having healed), and on the dorsum of the penis, about one inch above the corona glandis, is a small circular non-indurated erosion, with a reddish-white base, covered with small granulations secreting a small quantity of thin fluid. This has been there three weeks.

#### Pyrogallic Acid in Phagedænic Chancre.

Before the Paris Academy of Medicine (*Progrès Médical*, No. 1), M. VIDAL recently read a communication recommending the treatment of phagedæna by the following: R Acid pyrogallic, 20 gm.; vaseline, 80 gm. M. Or it may be used in the form of a powder by substituting starch for the vaseline. It is to be applied night and morning. As soon as the surface becomes healthy, simpler dressings are substituted, the sub-carbonate of iron being preferred.—*Med. Times*.

**Hydrotherapy in the Treatment of Syphilis.**

The *Medical Record*, quoting from the *Jour. de Med. de Paris*, No. 15, 1882, says that Dr. PASCAL advocates the employment of cold water, conjoined with the internal administration of specific remedies, in the treatment of syphilis. He states that it is of great service in its early stages, by virtue of its tonic effects, in overcoming syphilitic anæmia. In the later stages it is employed with advantage in the various cerebral accidents of specific origin. He condemns the thermal baths, however, as tending to cause the very cerebral complications for which the cure is sought. The cold bath alone is of little utility, but should always be regarded as an adjuvant to internal medication.—*Med. and Surg. Reporter*.

**Nitrate of Silver a Substitute for Mercury.**

Dr. P. GREENSWORD (*Med. Summary*): No close observer of the effects of medicine on the human system can fail to see that the absorption of mercury in the human body produces wonderful cures in a variety of diseases. From the time of Hippocrates to the present time, it cannot be denied that mercury has saved the lives of millions and has been a great boon to the human race.

But, while mercury, in many cases, has been a blessing, in some cases it has been a curse.

For the past twenty-five years I have been trying to find out a substitute for mercury, and I think the following facts will show that I have, at least, been partially successful.

The following prescription, which, for convenience, I will call No. I., has been my favorite remedy:  $\mathcal{R}$  Tannin, gr. ij.; argent. nitras, in crystals, gr. v.; pulv. gum acacia,  $\mathfrak{z}$  j.; aqua pluvialis,  $\mathfrak{z}$  vj. M. A teaspoonful fifteen minutes before each meal.

When the bowels were costive I gave a teaspoonful, occasionally, of the following mixture (No. II.):  $\mathcal{R}$  Pulv. aloes soc., Rochelle salts,  $\bar{a}\bar{a}$   $\mathfrak{z}$  j.; best whiskey,  $\mathfrak{z}$  ij.; aqua,  $\mathfrak{z}$  iv. M.

With these two remedies I cured several terrible cases of syphilis. Two of these cases were of the tertiary variety. In one of them there were ulcers in the throat; much pain about the nose, indicating some affection of the nasal bones and vomer, and red discolorations and much pain about the frontal bone.

In these two last cases there were sores over the tibia extending down to and affecting that bone, the discharge from which was very purulent and offensive. There were no other sores to treat.

For these sores I used, in addition to the internal remedies just mentioned, a poultice, repeated every three or four days, of four parts of ground flaxseed to one of powdered willow charcoal. These cases were permanently cured in one year.

In two other cases, a man and his wife, I used as an application to the fungus growth on the penis of the former, one part each of muriatic acid, chloride of zinc, blood root (in powder), and creosote. A few drops to be applied daily with a camel's hair-pencil. With the addition of the No. 1 and 2 internal remedies he was cured in a month.

For the ulcers on the os uteri of his wife I applied three times a week, with a camel's hair-pencil, the following: Powdered blood root, muriatic acid, tincture of iodine and creosote, one part each. She also used the No. 1 and 2 internal remedies, and was cured in three months.

If no other medicine is used this medicine will continue to act favorably on the general system for at least one year, because it remains a long time in the system.

In eye diseases I have been very successful in the substitution of nitrate of silver for mercury, as the following cases will show :

A man got sunstruck and became instantly affected with day blindness or Galeamaurosis, or cats' eyes. He could see like a cat in the dark. His eyes acquired a yellow tinge, but the No. 1 medicine gradually absorbed the extraneous growth in the front chamber of the eye and he was cured in three months. His eyes then lost their yellow color and again became black.

Another remarkable case was apoplexy of the front chamber of the right eye. In this case the front chamber of the eye, instead of being filled with transparent water, was filled with red blood. It was produced by a blow. The red blood was all absorbed and the eye became perfectly transparent and entirely well by using the No. 1 medicine for three months.

Another remarkable case cured by the use of the No. 1 medicine in two months was Hypopyon or a collection of pus in the left eye. The pus floated in the aqueous humor of the front chamber of the eye and produced so much pain that the patient did not sleep for two hours, night or day, for two weeks, until treatment was commenced. A strong solution of morphia was used as an eye wash and the No. 1 medicine was taken internally, and at the end of the treatment all the pus was absorbed.

#### DISEASES OF THE EYE AND EAR.

##### Purulent Inoculation in the Treatment of Granular Lids.

Dr. TERRIER formulates the following conclusions to an article on this subject in the *Revue de Chirurgie* for February, 1883: 1. Purulent inoculation is a good method of treatment of old conjunctival

granulations with pannus. 2. It is indicated where the pannus is thick. But corneal ulcerations and *pannus tenniss* are contra-indications to its employment.

3. In pannus, granular or not, affecting one eye, the procedure is to be practised with the greatest care lest the sound eye be inoculated. 4. The pus to be used is that of *ophthalmia neonatorum*. When this cannot be obtained gonorrhœal pus may be employed. 5. No attempt should be made to abort the induced ophthalmia, but it should be treated judiciously, with a view to prevent permanent injury to the cornea. 6. Sulphate of copper, nitrate of silver, yellow precipitate, ointment, or calomel insufflations are frequently indicated in order to complete the cure. 7. In exceptional cases it will be necessary to resort to syndectomy or iridectomy.—*Med. Record*.

##### The Cure of Strabismus by Glasses.

The *Practitioner* says that M. BOUCHERON (*Annales d'Oculistique*) recommends the use of corrective glasses in cases of convergent strabismus, an affection that is usually associated with hypermetropia or long-sightedness. The employment of appropriate corrective glasses must, however, be preceded, as Green recommended long ago, by the instillation of atropine to paralyze the accommodation, and the effect of the atropine should be continued for two or three months, if the case is seen at the outset, or for ten or twelve months if the affection has lasted some time. In fact, the employment of the atropine should be continued as long as there is any tendency to strabismus. The glasses ordered should be of sufficient strength to neutralize completely the hypermetropia present. When no further tendency to strabismus is observed the atropine may be discontinued, but the

glasses must still be employed. The strength of the atropine solution he uses is one part of the sulphate to 300 of water. If atropine produces any irritation, he uses duboisine. When strabismus is fairly established, he resorts to tenotomy, but even after this is performed, he instils atropine.—*Med. and Surg. Reporter.*

#### Treatment of Styes.

LOUIS FITZPATRICK, L.R.C.S., in the *Lancet*, says: The local application of tincture of iodine I have found, after many trials, to exert a well-marked influence in checking the growth of the sty. This is by far preferable to the nitrate of silver, which makes an unsightly mark, and often fails in its object. The early use of the iodine acts as a prompt abortive. To apply it the lids should be held apart by the thumb and index finger of the left hand (or a lid retractor, if such be at hand), while the iodine is painted over the inflamed papilla with a fine camel-hair pencil. The lids should not be allowed to come in contact until the part touched is dry. A few such applications in the twenty-four hours is sufficient, and I have never seen a single instance in which, after this treatment has been resorted to, the sty continued to develop itself.—*Med. Times.*

#### DIGESTIVE TRACT.

##### Intestinal Obstruction.

Operative treatment in cases of intestinal obstruction was the subject of a paper read by Mr. BENNETT MAY before the Midland Medical Society (*Brit. Med. Jour.*), in which the difficulty and importance of accurate diagnosis was dwelt upon. He mentioned the different operations between which

the surgeon might be called upon to choose, and arranged them according to subsequent mortality in increasing ratio as follows: 1. Colotomy in the joins. 2. Enterotomy by small incisions in the right groin through which the first distended and presenting coil of intestine was secured and made the site of an artificial anus without exploration. 3. Inguinal colotomy, by opening the sigmoid flexure in the left groin. 4. Laparotomy by median section, the cavity being explored, the cause of obstruction being removed and the wound closed again; or laparo-enterotomy if completed by opening the small intestine. He gave as the reasons for the lower death rate in enterotomy, as compared with laparotomy and laparo-enterotomy, that the conditions for which it was typically applicable were less acute and lethal, and the injury inflicted by the operation was less, and because it was undertaken earlier. He regarded it as a compromise between colotomy and laparotomy, and one which was always performed by many surgeons in cases where the indications to open the colon were not clearly marked. He thought, however, that there were cases in which laparotomy was the only proper operation, and in many he deemed it the better plan to open the small intestine as low as possible and stitch to the median wound, so making the operation a laparo-enterotomy. In impacted gall stones, if the calculus could not be dislodged by slight force, he would perform laparo-enterotomy, and if there was severe local pain and swelling, he would not confine himself to section in the median line, but would open the cavity near the seat of trouble. In cases of chronic obstruction of the small intestine, due to various causes, such as tumor, etc., and in many cases of obstruction of the large bowel in which the cause could not be

localised, he thought enterotomy the best operation.—*Weekly Med. Review.*

#### Intestinal Obstruction Treated by Rectal Tube.

Dr. J. FOSTER BUSH reports (*Boston Med. and Surg. Jour.*) three cases of intestinal obstruction, all of which came on after indulgence in improper food, and were relieved by injections through a rectal tube. The tube was introduced for a length of twenty inches, and injections of water were made once and sometimes twice daily through it, but a second was never given till the patient had recovered from the bad effects of the first.

In the first case mentioned the only time the injections were suspended for any length of time was when pain and intestinal spasm had been created; and whenever this is done, or whenever we have fear that the intestinal structures have been weakened by inflammation or ulceration, of course the injections would be contra-indicated.

Distention from below is not a new method, and other means than fluids have been employed. Air, for instance, has been forced in by means of a pump or bellows, or by chemical action, as by the injection of an alkaline followed by an acid solution. These last have only to be mentioned to be discarded, for they have not the soothing or relaxing properties of the water, which also exerts a force directly proportionate to the bulk employed, by reason of its compressibility and by its being regulated at will.—*Med. & Surg. Reporter.*

#### DISEASES OF THE SKIN.

##### Hints on the Treatment of some of the Parasitic Skin Diseases.

Dr. ROHÉ (Maryland Medical Association) opened the discussion of this subject with a paper. He confined his attention to diseases caused by vegetable parasites, *i. e.*, tænia favosa, tænia tricophytina and tænia versicolor. These are clinically distinct and easily discriminated.

Tænia favosa is rare in the United States—only forty cases were reported last year to the American Dermatological Association. It is characterized by the formation of yellow cup-shaped crusts on the head, each having in its centre a hair, and emitting an odor said to resemble that of mice. The fungus, consisting of mycelium and spherical spores is known as the *achorion Schœnleinii*. The object of treatment is the destruction of the parasite. The crusts are to be removed by soaking them in olive oil or lard; the hairs are then to be pulled out and parasitocides to be applied, as sulphurous acid or corrosive sublimate (gr. i. to iii. to the ounce). Baldness is liable to occur if the disease continue long.

Tinea Tricophytina or ringworm has received different names according to location. When involving the scalp, the stubby condition of the hair is distinctive. One stage of the disease known as kerion is characterized by an inflamed boggy and tender condition of the patch. The treatment of ringworm consists of cleanliness and carbolized oil (1 to 16) rubbed into the patch, after washing, so as to displace the fungus. The rest of the scalp should be included in the rubbing in order to prevent the extension of the disease. Sulphurous acid is also effectual, but there is a

liability to have the druggist put up sulphuric acid instead of sulphurous. Dr. Rohé had incised the boggy tumors of kerion and then inrubbed the oil in them with favorable result. Ringworm of the body is best treated by pure sulphurous acid applied to the patches. Ringworm of the face is usually gotten through the barber. An effectual application in this is corrosive sublimate, gr. i. to ii. to the ounce. In tinea of the beard or sycosis, all the tumors should be opened, and oleate of mercury, five per cent., freshly prepared, should be kept constantly in contact with the part. In ringworm of the thigh and genital region, or eczema marginatum, the inflammation and parasite both demand attention. Sulphurous acid should be applied, followed by ung. Hebra, or ung. oxid. zinc. Benzoic acid 3 i. to water Oj. is an effectual parasiticide and relieves itching.

Tinea versicolor consists of brownish or yellow spots over parts covered by the clothing. These spots are irregular and roundish in patches with intervals of sound skin. The most effective remedy is a lotion of the hyposulphite of soda—3 ss. to 5 j. water—applied after washing the part. The spots disappear in a week, but the remedy should be continued for a week or two longer. This affection is often treated for syphilis and the treatment has been known to be continued thus for years.—*Maryland Med. Jour.*

#### The Cutaneous Manifestations of Paludism.

The New York *Med. Jour.* says: In a paper on this subject by VERNEUIL and MERKLEN (*Ann. de Dermat. et de Syphil.*), the following are the conclusions arrived at: 1. Herpes is one of the common manifestations of malarial disease. 2. It may either precede the paroxysm of intermittent, or occur dur-

ing any one of the three stages of the paroxysm, or it may follow the stage of sweating. It may appear even after the paroxysms of the fever have been suppressed by means of sulphate of quinine. There is no etiological connection between the herpes and the fever, notwithstanding their frequent coincidence. 3. Paludic herpes does not present any peculiar features. Its most common locations are the face, the region about the lips and nostrils, the eyelids, the cornea, and such points as are most abundantly supplied with nerves. Though ordinarily discrete, in certain epidemics the eruption presents a remarkable tendency to confluence. 4. Black crusts, or, more especially, black vesicles, attending the herpes, pertain to grave and pernicious forms of malarial fever. 5. Exceptionally, the herpes of malaria takes the form of zoster. 6. The ordinary forms of malarial herpes may be preceded by and accompanied with vaso-motor disturbances upon the surface of the skin and disorders of sensibility.

It is believed, in consideration of the habitual locations of the eruption, of its concomitant disorders, of its possible appearance in the absence of a febrile attack, that the cause of the disease is referable to a nervous lesion, perhaps to a congestion of the cutaneous nerve-branches, resulting from the localization of the malarial poison in these nerves.—*Med. & Surg. Reporter.*

#### Medicated Gelatine in the Treatment of Skin Diseases.

Dr. PICK speaks highly of medicated gelatine in the local treatment of various skin diseases. It is a clean and convenient dressing, obviating the necessity of bandages or plaster to retain the application. After a bath the patient applies the gelatine, melted in a water bath,

with a brush, and after it is dry paints over it a thin coat of glycerine. The latter prevents cracking and chipping off of the dried gelatine, and also keeps it flexible, so that the joint movements are not interfered with. The following is the mode of preparing the medicated gelatine: Dissolve fifty parts of gelatine in one hundred parts of distilled water in a water bath. Then add the medication in the desired proportion, stirring constantly. Then set the mixture aside, and, when cool, wrap in oiled paper. The patient is instructed to melt a piece of this gelatine cake in a saucer set in hot water, and, when fluid, to apply with a camel's-hair pencil to the diseased surface. When it is desired to make a fresh application, the patient takes a warm bath and the old dressing is washed away.—*Allgm. Wiener Med. Zeitung*.—*Med. Record*.

#### Perchloride of Iron in Skin Diseases.

In the *Rev. Clin. di Bologna*, Dr. CARSARINI thus sums up his experience: 1. Perchloride of iron is a most efficacious remedy in purpura hæmorrhagica. 2. In the chloro-anæmia accompanying certain skin diseases—as rupia, eczema, impetigo, etc. 3. Its external use is very favorable in scrofulous and syphilitic ulcers. 4. Squamous affections are markedly modified by applications of a liniment of perchloride of iron. 5. It may be used as a lotion, dissolved in two or three parts of water, or as an ointment—one, two, or three grains of perchloride of iron to thirty grains of vaseline [cosmoline] or lard. The author has used it in psoriasis, in the form of a pomade—ten grains of iron, thirty grains of lard or glycerine.

#### Sycosis Parasitica.

An interesting case of sycosis parasitica was recently seen at Prof. NEUMANN'S

clinic in Vienna (Vienna Corresp. *Canadian Practitioner*): A middle-aged man had a well-defined soft tumor on his chin, about an inch in diameter. Its surface was smooth and flat, and the few short hairs still remaining were atrophied and broken. On squeezing it a quantity of serum was pressed out. It was five weeks since the patient first noticed anything there. In ninety-five per cent. of cases parasitic sycosis follows on herpes tonsurans, but here the surrounding chin was quite free from disease. This was but the eighth case Neumann had seen, and was thought to be due to the use of an unclean razor—the cause of ninety-five out of every hundred cases—though of seven seen previous to this the disease was proved in four to have come through infection from animals, two from horses, one from a cow, the fourth from a dog. In this case the diagnosis was proved by a microscopic examination of some of the removed hairs. The patient was treated by cleanly shaving the chin, and the application of a sulphur ointment. When seen again twelve days afterwards he was practically cured.—*Weekly Med. Review*.

#### Sulphurated Camphor Lotion.

The use of a formula of this description is often indicated in skin diseases, especially in pimples on the face. The following combination of M. VIGIER'S is much used in the Hôpital Saint-Louis: R. Aquæ rosæ, 250 gm.; spt. camphoræ, 30 gm.; sulphur. præcipitat., 20 gm.; pulv. acaciæ, 8 gm. M. secundum artem.—*Med. Times*.

#### Comedones.

The remedy is acetic acid, which is conveniently applied in the following way: Make an ointment of kaolin (potter's clay), four parts; glycerine, three parts; acetic acid, two parts. Cover the part affected in the evening; after several days most of them come out by washing with pumice soap.—*Am. J. Ph.*

# **FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.**

## **Angular Anchylosis of Femur at the Hip-Joint.—Treated by Subcutaneous Division of the Shaft at the Trochanter.**

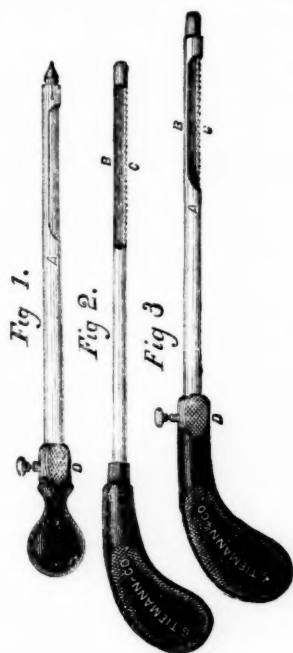
Dr. STEPHEN SMITH, (*Med. Record.*)

The patient was a young lady who suffered from disease of the hip-joint in early life, which resulted in ankylosis at an angle of about forty-five degrees. A year or two previous she had been under the care of the late Dr. James R. Wood, who endeavored to straighten the limb by force, but did not succeed. I gather from her statement that he did overcome the flexion somewhat, but that fact is not clearly made out. At the time when she first applied to me there was no perceptible motion obtainable at the joint, on the most careful trial.

The operation proposed was division of the femur just at the small trochanter, and the method selected was subcutaneous section with the fenestrated canula saw of Dr. Geo. F. Shrady. This saw has great advantages over any other form of bone-saw in this, that by working in a canula, the tissues beyond the bone are not liable to be injured by the point of the saw as it is moved backward and forward. The saw is described as follows by Dr. Shrady:

The instrument consists of a trocar, fenestrated canula (Fig. 1), and a staff (Fig. 2), with handle and blunt extremity. A portion of this staff at a short distance from the extremity is flattened, one edge (*B*) being made into a knife-blade, and the other edge (*C*) being provided with saw-teeth. This staff (Fig. 2) is intended to replace the trocar in the canula after the latter is introduced. When in position (Fig. 3), either the saw (*C*) or the knife (*B*) edge of the shaft, according to the way the latter is turned, corresponds with the opening in the can-

ula. The saw or knife can then be worked to and fro within the canula by a piston like movement, the canula being steadied by grasping the flange (*D*) at its base. If it be necessary to work the instrument as an ordinary blunt-pointed sheathed saw or knife, the shaft can be fixed in the canula and made into one piece by a thumb screw in the handle. The portion of the canula at the back of the opening is made extra strong and is of the same thickness as the blade, so



that in sawing there is no stoppage to the passage of the instrument through any thickness of bone. The soft parts are protected from injury no matter which way the instrument may be worked. The saw-blade is blunt at its extremity and is guarded on all sides except on its limited cutting surface. The same may be said of the knife. The working of the saw to and fro in the canula is sufficient in sweep to insure the division of any bone having a diam-

eter less than the length of the cutting edge. Still, as this process is much slower than when the saw is used in the ordinary way, it is perhaps better to restrict its employment to operations on the smaller bones, to cramped localities, and to situations where there is special danger of wounding some neighboring vessels. All that is necessary in using this saw is to thrust the trocar and canula into the limb, the fenestra of the canula being alongside of the bone upon which the operation is to be performed. The trocar is then withdrawn, the staff introduced in its place (Fig. 3) and worked as already described. The instrument is made of different sizes, to suit the different purposes for which it may be employed.

As one of the liabilities after the simple division of the bone is the displacement of the lower fragment from contact with the upper portion, so as to endanger non-union, I decided to attempt to overcome that tendency by making a half tenon and mortise by which the fragments would lock. This was easily effected by dividing the bone partially on the posterior and anterior surfaces, the incisions being separated half an inch or more, and breaking the interme-

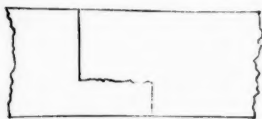


FIG. 4.

diate portion. The object sought to be accomplished is apparent from the following illustration (Fig. 4). Placing these two pieces in the position which the bone would assume after division, the relations of the fragments are shown in Fig. 5. If this conception of the operation is applied to the case in hand, the following illustrations (Figs. 6 and 7)

will correctly represent the procedure and the results.

The operation was as follows: The left thigh, being the affected limb, the patient was placed on her right side, which brought the left trochanter prominently upward. Selecting a point corresponding with the small trochanter, a sharp pointed knife was introduced to the bone. Along the track of the knife Shradys saw, sheathed in the canula,

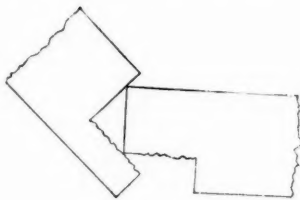


FIG. 5.

was passed, flatwise, until the blade of the saw was placed against the posterior surface of the femur at the point where section was to be made. The saw was then turned upon its axis so as to bring the teeth upon the bone. I attempted at first to hold the canula firmly, and work the saw in it, but found so much difficulty that I finally worked the whole as a common saw. The difficulty of fixing the canula seemed to be due to my inability to hold the canula firmly (the instrument being without the extra handle, *vide* Fig. 8), and to a bending of the canula in the track of the saw when the saw was withdrawn, which interfered with its return. It is possible that particles of soft tissue were also drawn into the canula, which prevented the saw from returning along the track. The saw, however, worked satisfactorily with the canula to guard its point. After penetrating to a depth supposed to be a little more than half the diameter of the bone, the saw was withdrawn from the posterior surface and passed along the anterior surface, flatwise, about half an

inch below the line of section of the posterior wall of the femur. Turning the saw to the bone, the section was made to a depth believed to be nearly on a line, in the long diameter, with the greatest depth of the posterior section. This fact was determined by inserting two probes in the cuts. At this point I

the saw. The truth was that the saw had cut the bone much more rapidly than they had supposed, for, on re-entering it, and making two or three passages, the bone separated in my hands.

The bone being divided while I held the limb, the assistants applied the plaster-of-Paris dressing. During the ad-

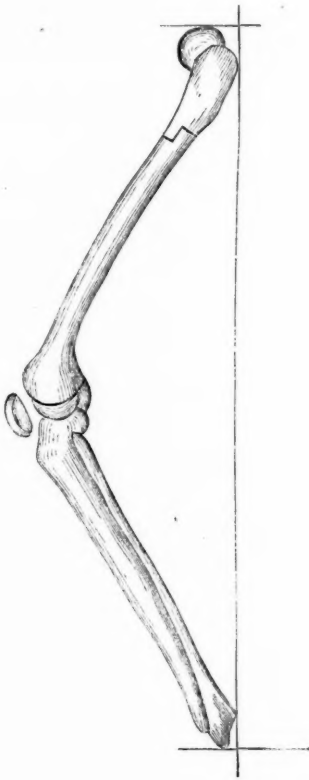


FIG. 6.

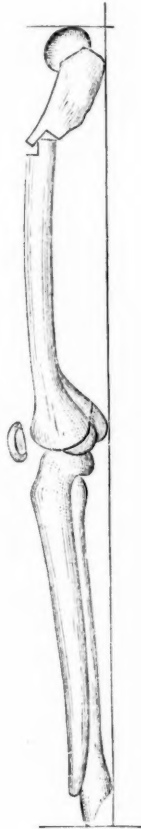


FIG. 7.

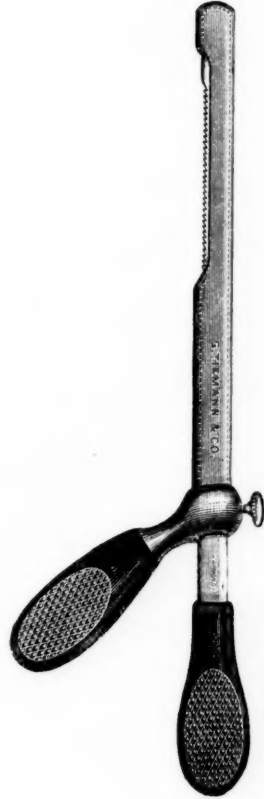


FIG. 8.

proposed to stop, and apply the plaster dressings, and break the intervening bone as the limb was brought down into the straight position. Some of the gentlemen present did not think that I had divided the bone sufficiently to insure fracture, basing their opinion upon the few movements which I had given to

justment of the dressings, the lower fragment of the femur twice slipped out of its interlocked position with the upper fixed portion, but it was readily replaced, and when returned remained quite firmly in the notch prepared for it. The limb was brought into the straight position while the plaster was yet moist. It soon

hardened, and then the dressings formed a splint, encasing two-thirds of both thighs, hips, and the lower half of the body. A fenestrum was cut out at the seat of the wound of the thigh. The wound had been hyperdistended with carbolized water, and then hermetically sealed.

The patient did well for two days, when menstruation began with great nervous excitement, which induced restlessness, sleeplessness, apprehensions of danger, and loss of appetite. It was more than a week before these symptoms subsided, when a superficial abscess was found to have formed, which extended down the external part of the thigh nearly to the knee. It discharged freely through the original wound, and by means of compressed sponges, accurately applied and firmly bandaged, soon closed. It could not at any time be made out that the abscess penetrated to the divided bone, and from the rapidity with which it closed there can be no doubt that it was altogether superficial.

The union of the bone progressed satisfactorily, and in about the usual period which is required for the consolidation of a fracture at this point, the patient was able to get up, and begin to use her limb. She now walks without any support, erect as she would with a healthy limb, and with but a slight halt.

The advantages of this method of operation, if any, are: 1, The subcutaneous nature of the wound; 2, the precision with which the bone can be divided at the desired point; and 3, the definitely fixed position which the fragments necessarily assume with relation to each other immediately on the division of the bone.

The only embarrassment experienced was the effort to work the saw in the canula. Failing in this, the saw and canula were worked together, and, as

the saw cut a groove sufficiently large to receive the canula, there was no difficulty in very quickly dividing the bone. The danger, however, of contusing the tissues on the inner side of the bone, by the end of the canula, is necessarily considerable, but in this case I am satisfied that the harm done did not interfere with the union of bone, nor the healing of the wound. Still it would be well to avoid the risk. On explaining the operation of the saw to Dr. Shradly, he modified the canula by making the fenestrum so small as only to expose the teeth of the saw (Fig. 8). As the teeth cut a groove which the canula readily follows, the canula, thus strengthened, will enable the saw to work easily in it, and at the same time will follow the saw in its section of the bone. This saw seems to me now to be the perfection of its class.

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**Removal of Extensive Cavernous Angioma of the Scalp by Means of the Elastic Ligature.**

DR. GEORGE R. FOWLER, of Brooklyn (Annals of Anatomy and Surgery).

Lizzie K., æt. 6 mos., born in the United States, of German parents, was presented at the Dispensary clinic, January 30, 1883, with the history of a congenital tumor, which had been slowly enlarging, although it had apparently caused the little one no particular uneasiness. Upon examination there was found an ovoid tumor, moderately soft and elastic, having no communication with the brain, but situated external to the right parietal bone at its posterior superior angle, covering an area about 7 cm. by 5 cm., and in its entirety raising the scalp about 2 cm., entirely subcutaneous, of a bluish color, and seemingly made up of enlarged capillary vessels and fibrous tissues. Its position favored free anastomosis of branches of the occipital and posterior temporal

arteries; no pulsation, however, could be felt.

On February 2d I performed the following operation: No anæsthetic was used. The scalp was first thoroughly washed with a 1 to 40 solution of carbolic acid, and ordinary antiseptic precautions adopted. Four straight nee-

tures occupied the relative positions represented by Fig. 2. "1-1, 2-2, 3-3, 4-4," each represents a separate and entire ligature; "*a, a, a, a, a,*" shows the point of entry and exit of each ligature, and the dotted lines indicate the course of each ligature beneath the scalp. Next the ends of elastic "1-1" were re-



FIG. 1. CAVERNOUS ANGIOMA OF THE SCALP.

dles without cutting edges were selected, threaded with common band elastic of pure gum rubber, and passed subcutaneously beneath one side of the growth in succession, each successive needle with its ligature entering at the point of exit of the last one. When this stage of the operation was completed, the liga-

threaded in turn, the needle in each case made to re-enter the original puncture at "*a,*" and keeping well down to the base of the tumor it was carried through and out of the opposite side. The remaining ligatures were carried across the base in the same manner in turn. The projecting ends of each loop

were passed through apertures in a narrow strip of sheet lead, then grasped by dressing forceps, made tense, and finally secured while thus tense by clamping with split shot.

Fig. 3 represents the completed operation; "a, a, a, a, a," original point of entry and exit and re-entry of ligature; "b, b, b, b, b," points of exit on opposite side; "c, c, c, c, c," apertures in strip of lead "d" for the passage of the ends of the loops, where they are secured by drilled shot. Thus it will be seen that the entire mass was enclosed subcutaneously in four loops of elastic ligature,

ing the use of an anæsthetic. The parts were covered with powdered naphthalin and absorbent cotton, drop doses of deodorized tincture of opium ordered in case the child gave evidence of suffering pain, and the parents directed to bring the patient to the clinic upon the third day following the operation. February 3.—Temperature,  $100\frac{1}{2}^{\circ}$  Fahr.; slight restlessness. Ordered half minim doses of tincture of aconite root every hour. February 4.—Child quiet and free from pain. Temperature,  $98\frac{1}{2}^{\circ}$  Fahr. February 6.—Removed dressings, tightened ligatures, again clamped

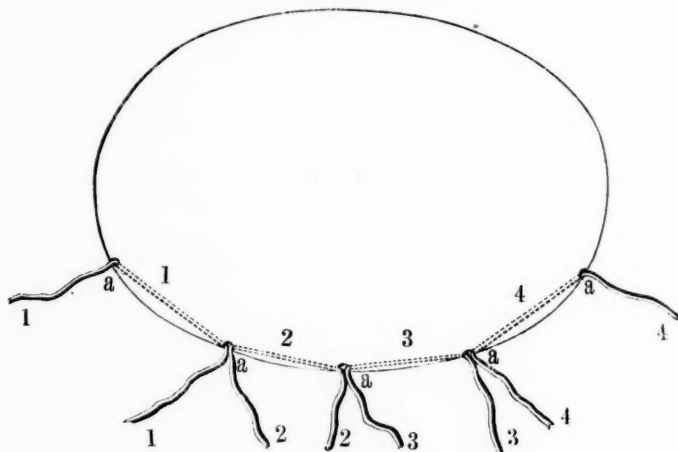


FIG. 2. RELATIVE POSITION OF THE LIGATURES.

and subjected to gradual, yet firm, constant pressure. It was hoped that healing would take place behind the ligatures as they cut their way gradually through the base of the tumor, as occurs when a fistulo-in-ano is treated in an analogous manner; therefore as much tension was not placed upon the loops as might have been exercised. Hæmorrhage was avoided, the entire operative procedure being completed with but slight oozing from the punctures in the scalp, and the attendant pain was surprisingly slight, not justify-

ing the use of an anæsthetic. The parts were covered with powdered naphthalin and absorbent cotton, drop doses of deodorized tincture of opium ordered in case the child gave evidence of suffering pain, and the parents directed to bring the patient to the clinic upon the third day following the operation. February 3.—Temperature,  $100\frac{1}{2}^{\circ}$  Fahr.; slight restlessness. Ordered half minim doses of tincture of aconite root every hour. February 4.—Child quiet and free from pain. Temperature,  $98\frac{1}{2}^{\circ}$  Fahr. February 6.—Removed dressings, tightened ligatures, again clamped

drug were observed. Irrigated granulating surface with 1 to 40 carbolic solution, and dressed with naphthalin. February 14.—Redressed with naphthalin. Granulating healthily. February 19.—Applied five skin grafts containing hair follicles, and dressed with naphthalin gauze. February 24.—Four of the grafts appear to have taken. Redressed as before. March 5.—New skin formation from margin of grafts extended to circumference of original granulating surface.

*Remarks.*—I am not aware that attempts have been made heretofore to

about one-half the area occupied by the growth. The method holds out the promise of being an eminently safe and satisfactory one in many respects; it is particularly applicable to the class of soft angiomas of the scalp of large size, where the use of the knife is contra-indicated, and the method of caustic treatment threatens to give rise to extensive cellulitis of the scalp. I have operated successfully in this class of cases by passing platinum wires parallel to each other across the base of the growth at intervals of a quarter of an inch, like the bars of a gridiron, and

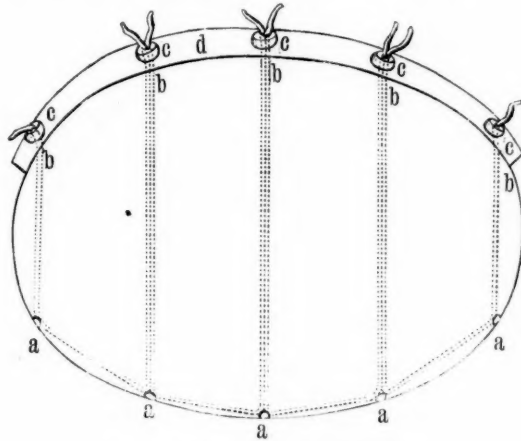


FIG. 3. THE COMPLETED OPERATION.

accomplish removal of these angiomas of the scalp by means of the elastic ligature. I expressed the hope, at the time of making this experiment, that, as the integrity of the scalp was maintained except at the points of entry and exit of the ligature, union would take place between the granulating surfaces behind the ligature, and that the result would be not a removal of the growth, but rather a modification of its character and a subsequent absorption of its degenerated elements. This was accomplished to some extent, for the resulting granulating surface was only

then touching the two ends of each piece of wire in succession with the conducting cords of a Byrne's galvanocautery battery, and thereby heating to a red heat the wires. This latter method, although very successful as far as ultimate results are concerned, is open to the objection of causing extreme pain at the time of the application. A much longer time is also needed for the sloughing process to throw off the mass, and the scar left after the cure is as large, if not larger, than the growth, and is generally quite a disfigurement.

### **The Pathology of Deaths from Burns.**

The *Medical Record* says that ZULLNER has published more extended reports of the examinations made by him of the corpses of those who perished in the burning of the Ring Theatre, in 1881. All the bodies, even those which exhibited no external marks of injury, were more or less covered with a thick layer of soot. The upper extremities were strongly abducted from the shoulder, the elbows were bent, and the forearms pronated, so that the backs of the hands lay near the face. A fighting attitude was thus simulated in some cases. This was due to shrivelling, and consequent shortening of the muscular fibres, by the action of heat. The large cavities, and more especially that of the abdomen, were often burst, even in bodies not otherwise much injured, and the bowels protruded. In females, the tympanic state of the abdomen frequently simulated a state of pregnancy.

The blood showed every grade of consistency, from the normal, through the viscid state, up to a completely friable dry mass, in which last condition the blood-pigment was found to be in an insoluble state. Occasionally, the blood formed a dull lustrous mass in the uninjured heart and blood vessels. Examined spectroscopically, the blood always showed the bands of carbonic-oxide-hæmoglobin, even in the case of bodies which had remained buried beneath rubbish for a month. In all the bodies which were incinerated, the heart was found in diastole, and rigidly distended with clotted blood. This sometimes gave rise to a suspicion of concentric hypertrophy; but the thin walls of the organ at once revealed the nature of the appearance.

The bones exhibited every stage of burning, from a simple combustion up

to a complete calcination. The jaw was most firmly closed. The muscles, where the skin was unbroken, had a boiled appearance; but, where they were charred, the odor was that of smoked meat. The drying-up of the flesh, and its permeation by pyrogenous products, obviously retarded the advent of putrefaction. In the eye, the application of lower grades of temperature manifested itself as a turbidity of the cornea, and complete opacity of the lens, giving the appearance of cataract. The larynx, trachea, and nostrils, were often filled with foreign material from the stomach, perhaps due to the vomiting excited by carbonic oxide. The urinary bladder was often full of urine, even when the abdomen had burst. Occasionally, where the bladder was empty of urine, it contained a gelatinous substance with embedded blood-corpuscles. This was found by E. Ludwig to consist of gelatine, probably derived from the connective tissue by the action of heat. Similar gelatinous masses were found in the uterus in some cases; and this organ was found to be very resistant to the action of heat.

### **Temperature of the Joints.**

Dr. REDARD has been conducting a long series of observations to determine the local temperature of the joints in health and disease, and has arrived at the following conclusions: The temperature of the skin overlying the joints may fluctuate through  $7^{\circ}$  to  $10^{\circ}$  from external causes. The local temperature of the joints falls in proportion to their distance from the body. It is always higher on the flexor than on the extensor surfaces, ranging in the larger joints from  $87^{\circ}$  on the latter to  $96^{\circ}$  on the former. Joint motion causes an increased temperature not only of the articulation but also of the whole limb. Continuous

movements of flexion and extension of the ankle for five minutes will raise the temperature of the entire limb nearly a degree. Thermometry of the joints in diseases is of value only in the superficial articulations. In hæmarthros the temperature rises after the third or fourth day and remains more or less elevated according to the nature of the resulting inflammation. In traumatic joint suppurations the local temperature sometimes reaches the same height as the general, but is never seen to rise above it. In rheumatic, gonorrhœal, and puerperal joint inflammations there is a considerable increase of heat, frequently of the entire limb. In joint effusions following fracture of the long bones there is an increased temperature after a few hours. This would indicate that there is a contusion of the joint with an inflammatory tendency, and not a simple effusion. In white swelling the temperature of the surface over the fungous granulations is raised from  $\frac{5}{10}^{\circ}$  to  $\frac{9}{10}^{\circ}$  above that of the neighboring parts. In caries sicca there are no characteristic changes to note. In old ankyloses we sometimes find an elevation of from one to two degrees. This shows that the inflammatory process has not fully subsided, and may thus furnish an indication for treatment.—*Centralblatt für Chirurgie*.—*Med. Record*.

#### A New Protective.

Dr. MALININ (*Mediz Obozr.*) recommends mixing, collodium lb. j.; castor oil, 3 j., almond oil, 3 ss, and carbolyzed oil, 3 iij.—3 iv., and spreading it over a glass plate smeared with glycerine. The fluid rapidly dries, forming a transparent, thin, soft, and light sheet, which, when used, suffers no alterations from the contact with wound-discharges, and may be employed repeatedly (of course, each

time after its washing in a carbolic solution.)

#### Colorless Tincture of Iodine.

C. S. JOHNSON, Carthage, Ohio, writes that he finds the following "a decided success," in the preparation of colorless tincture of iodine: R Tinct. iodine, 7 drachms; aquæ ammonia, 1 drachm; carb. acid, 10 drops. Shake a few minutes; keep from the light.—*Druggist*.

#### Chromic Acid.

Chromic acid in solution has been used by Mr. HENRY T. BUTLIN (*Practr.*) in certain inflammatory states of the tongue, with good results. The strength of the solution used was ten grains to an ounce of water, which was painted over the parts with a camel's hair-brush. Cases of chronic superficial glossitis caused by immoderate smoking and drinking, and frequently combined with syphilis improved under the use of the solution; but it was in secondary syphilitic ulcerations, mucous tubercles and condylomata, that its greatest benefit was seen, a few days sufficing for their cure. He says that the raised areas accompanying these affections rapidly subside, and the red areola surrounding them disappears, the mucous membrane returning to the normal color. He says there is no pain caused by the application, though at first there may be a little smarting.—*Weekly Med. Review*.

#### Suture-Clamp Coaptation.—A New Method for Closing Wounds.

Dr. J. H. CIPPERLY (*Med. Record*): To the means ordinarily employed in repairing a lacerated or incised wound—bandages, adhesive strips, surgical pins, and the various sutures—another, a new and facile method, is obtained with what I am pleased to call, in the want

of a better term, a suture-clamp. Made of hard silver wire, bent at acute angles at both ends, the extremities of the arms sharpened to a point.

One hand supports the severed parts together, while the other introduces a clamp, penetrating one lip at a time, and introducing a clamp at regular distances until the coaptation is complete. Their position is retained by the tight grasp of the skin and tissues on the arms of the clamps, supplemented by the inclination of the arms toward each other. A moment's consideration of the advantages of this method: the most striking are the ease and rapidity with which you close the wound. A single instrument is all there is at hand; you do away with needle, wire, needle-forceps, scissors, and the trouble accompanying them. In the closure of the wound there is less constriction to the lips than results in the use of sutures or pins, where the swelling often causes a tearing out; thus is aided the better work of repair. The arms of the clamp sustain both walls, so that the deeper parts of the wound conjoin, and there is less opportunity for the pocketing of blood and pus, and more rapid healing. Again, there is the minimum of pain attending their introduction and they are removed without pain, and may be used again. Made of various sizes (usually required but three or four), their application is general. With short arms they may be used in scalp wounds and over bony places. In wounds where there is contusion and laceration and gaping, long clamps reaching across will produce a partial union at least, otherwise not attained. The first application was made in the case of an injury where the toes and portions of the metatarsal bones were removed, a buzz-saw accident leaving a single flap from the plantar surface of the foot, and

rather short to cover the exposed bones. Five clamps were applied that closed the wound, and were allowed to remain six days, when adhesive plaster was brought into play, as the wound was healing by granulation. In this first instance their ready, time-saving usefulness was at once clearly demonstrated. This occurred in March, 1882, and I have since made use of them repeatedly, and with the uniformity of repeated satisfaction in their success.

*Suture-clamp for wounds.*—I. Is a new method.

II. Is made of hard silver wire by preference.

III. Has advantages: 1, Of rapidity in application; 2, of a single instrument at hand; 3, of less constriction; 4, of better coaptation; 5, of but little pain on introduction and removal; 6, that it may be used again; 7, of partial union in gaping wounds.

IV. First used in March, 1882.

## VENEREAL DISEASES.

### Syphilitic Hepatitis in Children

Is an affection which is not generally easily recognized. Dr. HUGO ENGEL (*Am. Jour. of Obstetrics*) says: That although the child when very young may have shown some indications of syphilis, they are generally forgotten from their disappearance after the use of calomel, given either accidentally or intentionally. He says that the syphilitic hepatitis of children resembles the cirrhosis of the liver, caused by alcohol, but that the cirrhotic process is not as uniform as in the latter. There is an irregularity in the outline of the organ, caused by a sinking in, as it were, of large patches, while the margin remains smooth. It differs from the alcoholic

variety in that, with the appearance of this irregularity, there is no diminution in the size of the gland, but, on the contrary, it is still very much enlarged. With this disease there is, he says, a peculiar color of the skin and a cachectic appearance, dyspepsia, and ascites, which gradually develops; there is no pain and little or no tenderness.

The treatment consists of mercurial inunction and potassium iodide internally, in doses of two to forty and sixty grains, three times a day. An increase in the dose of the iodide is made every third day, and it is continued until the trouble has disappeared, when the patient is placed upon tonics.—*Weekly Med. Review.*

#### Syphilis.

Syphilis was introduced into Europe in 1492, and first treated by inunction in 1497. Paracelsus first gave mercury internally in 1570; and until 1812, in this country, there could be little doubt that mercury had poisoned fatally perhaps as many patients as had been killed by syphilis, which until 1836, when Wallace, of Dublin, published in the *Lancet* his account of the treatment of tertiary syphilis by iodide of potassium, must have been a terrible disease.—*Dr. Drysdale, of London.—Med. Times.*

#### Gonorrhœa of the Rectum.

THIRY (*Presse Méd. Belge*) believes in the reality of gonorrhœal inflammation of the rectum, an affection which is not recognized by many authors. In support of his opinion, he relates the following case: A woman, aged twenty-four, a clandestine prostitute, was admitted into the Hôpital St. Pierre, Brussels, complaining of weight and shooting pain in the pelvis, pain in defecation, and a constant thick discharge from the bowel.

Walking also was difficult. On examination, there was a well-marked funnel-shaped depression of the anus, the anal folds were obliterated, and the sphincter was weak and dilated. A vaginal speculum of ordinary size passed easily and without causing pain. On washing away the abundant thick discharge, the lower portion of the rectum was seen to be acutely inflamed and studded with bright red points, which bled when wiped with wool. The follicles in the rectal folds were enlarged and discharged pus. The patient confessed that she had had relations with men who were suffering from clap. Solution of borax was used locally at first; afterward red cinchona bark was applied to the mucous membrane, and, finally, an injection of oak-bark was used. Under this treatment, combined with sitz-baths and the internal administration of iron, the woman recovered in about three weeks.

#### Belladonna in Gonorrhœa.

Dr. J. NUMA RAT states in the *Lancet* that he has treated a few cases of mild gonorrhœa successfully by smearing the penis with ointment of belladonna and enveloping it in a cloth smeared with the same. No injections were used nor internal medicine employed, and the cure was complete in a week.—*Med. & Surg. Reporter.*

#### For Gonorrhœa.

R Pulv. acaciæ, ʒj.; spts. ætheris nit., bals. copaiba, aa ʒij.; tinct. opii, ʒij.; sacch. alba, ʒj.; aqua font., ʒiv. M. Sig.: One teaspoonful four times daily.—*Med. Med. Journal.*

#### Pruritus Urethræ During Gonorrhœa.

In the *Journal of Cutaneous and Venereal Diseases*, Dr. WM. L. AXFORD mentions a most intense itching of the urethra often observed during the third

stage of gonorrhœa. All treatment was unavailing until he found that distention of the urethra afforded relief. The passage of a catheter, however, increased the inflammation, so he resorted to the following expedient, which he has found successful: The patient was directed to hold the end of the penis firmly between the thumb and index finger in such a way that no urine can escape, then to make an effort to micturate, thus thoroughly distending the urethra and keeping it so for one or two minutes, the sensations of the patient to be the guide as to the amount of force to be used.—*Ibid.*

#### Discharge of the Urethra.

The relation of the state of the urethra to the discharge is a question that has been discussed a great deal (*Jour. de Med. et de Chir. Pratiques*). According to many authors, whenever there is gonorrhœa, a certain amount of stricture occurs, and this ought to justify a speedy employment of bougies. M. GUYON, on the contrary, considers as well demonstrated that almost always stricture plays no part in the production of chronic urethritis. M. Janin, one of his internes, who has written an important paper on this, found that in sixty-one patients affected with chronic urethritis, four only had stricture. This fact is of great importance from a therapeutical point of view, since it demonstrates there is no necessary relation at this stage of gonorrhœa between the two morbid states. It is the same in regard to narrowness of the meatus, considered by some as a cause of chronic urethritis; and, on this account, cutting the meatus has been overdone, an operation which M. Guyon has very seldom practiced in this condition.

#### Salicylic Acid in Soft Chancres and Buboës.

AUTIER (*Th. de Paris*) says: 1. The efficacy of salicylic acid in the treatment of soft chancres and of buboës appears to us to be unquestionable. While not an absolute specific, it is, in our opinion, capable of being most advantageously employed. 2. Oderless, only slightly painful in its application, soluble in alcohol and glycerin, and leaving no stain on linen, it is preferable, in these important respects, to most other agents employed for the cure of the above-named affections, while perhaps inferior in certain other particulars to some among its rivals. 3. It may be resorted to in all cases, both when the sores are large and well exposed, and when they are sloughing extensively, or are reached with difficulty; and it is equally available in private and in hospital practice.—*Med. and Surg. Reporter.*

#### Dr. Cattaneo's Treatment of Hydrocele.

From the *Jour. de Med. de Paris* we note the following treatment recommended by Dr. C.: 1. Puncture of the hydrocele with a capillary trocar of an aspirator, and evacuation of the fluid. 2. Injection of a solution of hydrate of chloral in quantity proportionate to the volume of the hydrocele and age of the patient: one to two grams of chloral for children, four grams for adults, and occasionally more in old men. The solution is made by dissolving equal parts of chloral in cold distilled water. 3. Cold applications to overcome the pain produced by the injection. 4. The injection is repeated if the absorption occurs too slowly. The patients are kept in bed, and wear a suspensory bandage for some time after the termination of treatment. Dr. Lampagnani says that the effusion has not returned in any one of the seventeen cases operated upon by this method.

**Hydrocele.**

A radical cure in the case of hydrocele was accomplished by Mr. J. E. W. WALKER (*British Medical Journal*), by injecting, through mistake, two drachms of liquor ergotæ (Battey) instead of the same quantity of tincture of iodine. There was no pain and no bad results followed. This occurred in 1875, and although previous to the accident there had been repeatedappings, no return of the abnormal secretion has taken place since. Seeing the good effect produced in this case, he has tried the same remedy in two other cases with equal success.—*Weekly Med. Review.*

**Hydatid Cyst in the Prostrate Gland.**

At a recent meeting of the Société de Chirurgie, M. TILLAUX reported the following interesting case: A man, 43 years of age, presented himself at the hospital, suffering from retention of urine and rectal obstruction. On local examination, a large tumor was found in the rectum; there was intense pain, which seemed to increase rapidly in intensity. M. Tillaux, considering it to be a liquid collection, made an incision, which was followed by the issue of a large quantity of clear liquid. The following day a small hydatid was found in the discharge, and others appeared for several days after. Hydatid cysts occupying the prostrate gland itself are of very rare occurrence, but Davaine made mention of such cysts in the cellular tissues about the prostrate and other organs of the pelvic cavity.—*Med. and Surg. Reporter.*

**DISEASES OF THE SKIN.****Acne.**

Dr. J. LESLIE ORMSBY (*Can. Med. Record*): You will find the following treatment of acne to be the most satisfactory:

The face should be steamed every night by holding it over a basin of hot water for a few minutes. The skin should be then well rubbed for five or six minutes with soap and flannel, or a soft nail brush may be used with advantage when the skin will bear it; the soap should then be sponged off with warm water. When the face has been dried the following lotion should be applied, and allowed to dry and remain on all night:

R Sulphur precip., ℥ ii.; glycerini, ℥ ii.; spt. vini, ℥ i.; aquæ calcis, aquæ rosæ, āā ℥ iii. M.

In inveterate cases of acne the following will be found particularly serviceable:

R Sapo mollis, ℥ i.; spt. rectificate, ℥ iss.; ol. levandulæ, M xx.; aquæ ad, ℥ vi. M. Ft. lot.

The lotion should be applied with a piece of flannel and vigorously rubbed on the skin. It should be washed off and then the sulphured lotion applied. In treating diseases of the skin one should always bear in mind the late Professor Hebra's admirable advice: whatever course be adopted, constancy and perseverance are of the utmost importance. He who is always changing his plan of treatment is sure not to attain his object so quickly as one who steadily and patiently applies whatever remedy seems best suited to his case.

**Lappa Minor in Psoriasis.**

Dr. W. C. REITER (*Squibb's Ephemeris*) claims that the use of a tincture of burdock seed has yielded excellent results in the treatment of psoriasis. The tincture is made from one part of burdock seed ground fine, and macerated with eight parts of diluted alcohol. The dose is a teaspoonful.—*Med. Record.*

**Treatment of Premature Baldness.**

In the *Berliner Klin. Wochenschrift*, Dr. LASSAR discusses the etiology and

treatment of early baldness, or alopecia prematura. From observation and experiment upon animals it was found that the disease is contagious, and occurs independently of any general affection or the state of health of the patient. The method of treatment recommended is as follows: The scalp is to be washed every day with tar soap, or soft glycerine soap, or with soap containing sodium iodide; the soap is to be thoroughly applied, and rubbed into the scalp for fifteen minutes. Following this is a warm douche; then by the application of a corrosive sublimate (two parts per one thousand) the hair is dried, and a half per cent. spirit solution of naphthaline is rubbed into the affected portions. Carbolic or salicylic acid may also be employed if desired. If this treatment be adopted in the early stage, when the hair is just beginning to fall, it has usually proved successful, but it must be kept up for eight weeks or more. The fact that this disease is due to a communicable morbid principle has been brought up in order to show its conveyance by the comb and brush of the barber.—*Ibid.*

#### A Treatment of Acne Rosacea.

M. BOUCHUT, in *le Paris Medical*, recommends the following preparation: R. Aquæ destill., ℥ v.; aq. rosæ, ℥ iij.; spts. camphoræ, ℥ iiss.; sulphur sublimat., ℥ ss. to ℥ j. M.

This is used as a lotion and is applied to the affected parts at night with a soft sponge and allowed to dry. The next morning it is washed off with water as hot as can be borne, which has been previously boiled to rid it of all traces of chalky matters.

This treatment should be continued for some time, and when the pustules have disappeared, linear or punctated scarifications should be practiced, to

divide the cutaneous vessels and induce complete cure of the redness and thickness of skin which remains.—*Med. & Surg. Reporter.*

#### Hyperidrosis of the Axilla in the Nude Subject.

Dr. AUBERT reaches the following conclusions (*Annales de Dermatologie et de Syphiligraphie*) from a study of this phenomenon in a large number of individuals: 1. Axillary hyperidrosis is almost always present in nude subjects. 2. This is so great in many instances that streams of perspiration may be observed running down the body and inner side of the arm. 3. The chief cause of this phenomenon seems to lie in the anatomical disposition of this region permitting of a local elevation of temperature, while that of the general surface is lowered by the surrounding atmosphere. 4. This local elevation in a number of instances amounted to nearly 1° F. 5. Various facts lead to the supposition that this elevation of temperature finds in the glands of Robin an organ favorably disposed, by its innervation and structure, to the reception of thermic influences. 6. The mental effect produced by nudity and examination may aid in causing an increased secretion, but it plays a very subordinate rôle in the production of this phenomenon.—*Med. Record.*

#### The Influence of the Nervous System upon Pathological Changes in the Skin.

In a valuable contribution to the *Vierteljahresschrift für Dermatologie und Syphilis*, Drs. ARTHUR IRSAI and VICTOR BABESIM, of Budapest, call attention to an important series of experiments upon animals, in which various lesions of the central nervous system produced pathological conditions of the

skin. The influence of the sympathetic nervous system over the skin was especially studied, and the authors conclude that their experiments demonstrate a direct connection between disease of the sympathetic and certain affections of the skin.—*Med. Times*.

#### **Solution of Cayenne Pepper in Glycerine for Tinea Tonsurans.**

In the *Mississippi Valley Medical Monthly*, Dr. G. W. OVERALL reports two cases of tinea tonsurans, where the head was almost bald, with a few dry, dead-looking hairs scattered over it; the dry scaly crusts extending all over the head. All the usual remedies were unavailingly tried. Finally the head was cleansed with a solution of sulphite of soda, and then on alternate days a saturated solution of cayenne pepper in glycerine was applied. This produced most satisfactory results.—*Ibid*.

### **DISEASES OF THE EYE AND EAR.**

#### **The Effect of Noise on Healthy and Diseased Ears.**

Dr. D. B. ST. JOHN ROOSA read a paper on this subject before a recent meeting of the New York County Medical Society (*Boston M. and S. Jour.*), in which he summed up his experiments somewhat as follows: 1. A large class of persons suffering from deafness can hear quite distinctly when in a noise. 2. When this is the case, the disease is situated in the middle ear. The disease is usually of a chronic, non-suppurative character; but the same phenomenon is also noticed sometimes in acute and subacute affections of the middle ear. 3. The proximate cause of this is not yet definitely determined, but it is believed to depend on the condition of the ossicles.

4. Boiler-makers' deafness is of an altogether different character from the above. 5. The latter is believed to be due to disease of the labyrinth or the trunk of the acoustic nerve. 6. Those suffering from boiler-makers' deafness do not hear better in a noise. 7. Cases of impacted cerumen and other affections of the external and middle ear occur in boiler-makers as well as in other individuals. 8. In diseases of the labyrinth the tuning-fork C is heard louder and longer through the air than through the bones of the head.—*Ibid*.

#### **Hydriodate of Hyoscyamin.**

And now we have yet another rival to atropia in ophthalmic therapeutics in the shape of the hydriodate of hyoscyamin. A report of twenty cases in which it was used at Prof. Seeley's clinic is published by Dr. TANGEMAN in the *Cincinnati Lancet and Clinic*, May 5th. In all cases only one drop of a four-grain solution was used. The ciliary muscle is affected in five minutes, while mydriasis is usually complete in ten minutes. Even spasm of accommodation yielded in this time. The parietic condition begins to disappear in thirty-six to forty-eight hours, and accommodation is normal in four or five days. In the matter of time, then, it holds a place between atropia and homatropia. It is moreover claimed that it causes much less dryness of the throat or other disagreeable symptom than either atropia or duboisia, while producing its first effect quicker than either.—*Weekly Med. Review*.

#### **Is Distilled Water in all Cases the Best Vehicle for Eye Lotions?**

In the *Practitioner* for May, 1883, Dr. PAUL M. CHAPMAN claims that it is not, saying: "I have tried the experiment on myself and on many of my friends,

and the answer is always the same, viz., that the introduction of distilled water into the eye is attended with much discomfort and smarting, while with normal saline there is no noticeable effect whatever.

"The practical deduction is this, which I have also verified, that the addition of two and a half grains of chloride of sodium to the ounce of distilled water renders any lotion intended to be of a soothing character much more beneficial."—*Med. and Surg. Reporter*.

#### The Management of Strabismus Convergens.

Dr. D. B. ST. JOHN ROOSA. The management of strabismus convergens was formerly supposed to be a very simple affair. When Donders showed its relations to a short antero-posterior diameter of the eyeball, a new importance was attached to it. It was found that mere division of the *rectus internus* was not always sufficient to cure the squint. The ciliary muscles and the internal recti act together. If you paralyze the ciliary muscles by the use of atropia, you at the same time lessen the power of the internal rectus. In the use of this drug, therefore, a means of dispensing with the operation was found by some authorities. But full trial has proved that these hopes of cure without cutting are usually illusory, and the division of the muscle has as firm a hold upon the profession as ever. But the use of atropia *after* the operation, the use of glasses *after* the operation are often—yes, generally necessary, to effect a cure.

In the forty cases that have been operated upon in this division of the hospital since November 1st, atropia and glasses have been required in nearly every case. Any one may soon acquire the mechanical skill to take up the in-

ternal rectus on a hook and to divide it close to its insertion with a scissors; but to learn what is known about strabismus convergens, and to appreciate the gaps in our knowledge, will require some months of careful study and close observation. It is not the simple subject that Diffenbach thought it. Perhaps I may say, it is not yet as clearly understood as even Donders supposed his observations had made it. If hypermetropia be the chief cause of convergent squint, why do so small a proportion of hypermetropics squint? A large percentage of the people of the world who are not *myopic* are *hypermetropic*. Yet very few of the latter squint. Why is one operation sufficient to cure some cases of marked strabismus, while two or three, or even four, are sometimes needed for some, in which the deformity is slight? I am not able to tell beforehand in which cases I shall be obliged to operate twice or three times. I always tell the friends of the patient beforehand, that to get a good result they must leave the case to my observation for at least six weeks.

You have observed that although I make a free incision into the conjunctiva and into Tenor's capsule, that I never use a suture after the operation. I do not *usually* find any difficulty afterward in the way of a cicatrix or granulation. It is easier to snip off a granulation if it came than to take out a suture. The child generally regards the cutting a suture as another operation, and dreads it accordingly. We have had but one case of inflammation of the edges of the wound this winter. In all the cases, except those just performed, I finally "straightened the eyes." In a few months after the operation, I usually advise that the use of glasses, as for young hypermetropics in general, be given up, except for close work. Their use is, however, essential in the first few weeks after the operation is performed. I know of no subject in ophthalmology that will better repay study, and in which there is a better prospect of new contributions to our knowledge, than this of the management of strabismus convergens.—*The Planet*.

## FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

### Some Questions with Reference to Intra-Capsular Fracture of the Femur.

Dr. E. M. MOORE, of Rochester.

After reporting several cases and illustrating his remarks with a number of specimens showing bony union after fracture of the neck of the femur, he submitted, in conclusion, the following suggestive questions :

1. Is not the cause of fracture of the neck of the thigh-bone, whether intra or extra-capsular, almost uniformly a blow upon the trochanter ?
2. Is not the preservation of the periosteum of the neck (called, in connection with the reflected capsule, the cervical ligament), although only partial, the common rule, and not the exception ?
3. Does not this condition, if preserved, supply nutriment to the upper fragment sufficient to entire repair ?
4. Is not the outer layer of what is called the periosteum of the neck a rudimentary organ ?
5. In *reputed cases* of absorption of the neck, after blows upon the trochanter, said to be without fracture, is it a reasonable—much less a perfect—induction to infer a similar result when the changes of condition are similar only in one point, and dissimilar in every other, those of inflammation without a blow ?
6. Should not the induction read thus ? The head of the femur and the acetabulum not being altered, the shortening of the neck could not be from inflammation resulting from the blow. Finally,
7. Does not the practice of modern surgeons produce vastly improved results in the cases treated by them, as

compared with the method of the last generation ?

Dr. Moore recommended the use of moderate counter-extension, with lateral support and the horizontal position, in the treatment of injuries of the head of the femur, even when the existence of a fracture cannot be absolutely recognized.—*Louisville Medical News*.

### Rupture of the Sciatic Nerve Mistaken for Fracture of the Neck of the Femur.

Dr. KÜSTER relates the following case in the *Berliner klin. Wochenschrift* : The patient, while walking, slipped and fell backward. He experienced a severe pain in the right leg and numbness of the foot, and was unable to rise. When seen the following day he was suffering intense pain in the limb, which was rotated outward and apparently shortened. Pain on pressure was most severe in the neighborhood of the hip-joint, where there was also a slight swelling. At the first glance the case was apparently one of fracture of the neck of the femur. This diagnosis had been made guardedly by two other physicians, who had seen the patient shortly after the accident, but had made no examination on account of the agony which he was suffering. Dr. Küster could, however, obtain no crepitation, and, moreover, passive movements of the joint occasioned little or no pain. A diagnosis was made of rupture of the sciatic nerve, and was confirmed by the subsequent conduct of the case.—*Med. Record*.

### Ignipuncture.

KOLOMNIN, of St. Petersburg, has recently taken occasion (*Boston Med. Jour.*) to recommend ignipuncture as of greater use in many joint affections than the actual cautery, extension, or even immobilization. He considers it indi-

cated in all fungous troubles about the joints during the period of bony growth in which there is enlargement and tenderness of the epiphyses, and in coxitis where the disease originates in the femoral epiphysis. It is the best treatment in osteitis of the foot and wrist in children, in tuberculous osteitis and osteomyelitis. The best results are obtained in cases where there is pain in movement and tenderness of the articular ends of the bones. In cases of chronic synovitis, with absence of pain and tenderness, the results of this treatment are naturally not so favorable. An anæsthetic should always be used. The thermo-cautery is the most convenient instrument for the purpose. Strict antiseptic precautions are essential. One may make (1) superficial punctures, burning more or less deeply the infiltrated tissues about the joint; (2) cauterization to the bone and its superficial surface; (3) cauterization of the integument, infiltrated tissues, surface of the bone and part of the spongy structure; (4) cauterization of the marrow and epiphysis after trephining through the latter. This line of treatment, in the opinion of the editors, bids fair to show better results than have ever before been attained in the treatment of tuberculous disease of the bone, and is the one he has already recommended and practiced in those cases.

#### The Coat-Sleeve Amputation.

Some time since we referred to this operation of Mr. DAVY's (*Brit. Med. Jour.*), in which a circular incision is made, the tissues dissected up, the bone sawed through, and the tissues brought together as one would the end of the coat-sleeve. Dr. L. Colbourne, of Buenos Ayres, writes to the *Brit. Med. Jour.* that, having occasion to amputate the leg of

a fairly muscular man, he found it impossible to turn the tissues up, when the diameter of the leg was (as in robust people it always will be) greater above than at the point of incision. To obviate this difficulty, he made a longitudinal incision in the posterior aspect of the flap.—*Med. and Surg. Reporter.*

#### A New Styptic.

Dr. HILL, of Goldsboro, told the Medical Society of the State of North Carolina, at its last meeting, that he had used ambrosia trifida, or rag-weed, in epistaxis, pulmonary and uterine hemorrhage, hemorrhage from the bowels, hemorrhagic diathesis, etc., and found it of great value.—*Ibid.*

#### Chloral Hydrate as a Vesicant.

Dr. F. D. RITTER (*N. Y. Med. Jour.*) says: "Some three years ago I accidentally discovered that when powdered chloral, sprinkled upon ordinary adhesive plaster and melted by a gentle heat (not more than enough to cause the plaster to adhere to the flesh), is applied warm to the part where the blister is wanted, within three minutes a gentle heat is felt, increasing in intensity for about three minutes more till it is like a burn, then gradually easing off, until, at the end of ten minutes, the parts feel free from pain. The secondary effect is soothing; in some instances, within half an hour a second burning is felt, though not so intense as at first, nor so lasting. If, at the end of ten minutes, or as soon as pain has subsided, the plaster is taken off, the surface is found as effectually denuded as by a cantharidal plaster after six hours, though the discharge is not so great. Thus within ten minutes the work of an old-fashioned blister is accomplished, and the great advantages of the chloral plaster over the cantharidal

are: 1st. Its rapidity of action, thus relieving pain, and producing the counter-irritation upon an engorged organ before the congestive action has had time to pass into more than the congestive stage; 2d. Its ease of application; 3d. It need never be taken off to have the blister dressed, but the original plaster may remain until the sore is entirely healed, and the plaster loosens and comes off of itself."—*Med. & Surg. Reporter*.

#### Treatment of Furuncles.

It is well known to-day that the matter of furuncles is inoculable spontaneously, and it is considered that this spontaneous inoculation is encouraged by the softening of the epidermis from the employment of the poultice so often used in this affection. The primitive boil becomes thus the point of departure for secondary ones, which manifest themselves in the neighborhood. To prevent this inconvenience, M. LABBÉ had the idea of employing successively for the dressing of furuncles a solution of chloral or phenic acid, but he perceived that this dressing, which was undoubtedly antiseptic, did not hinder the softening of the epidermis: it was thus he had recourse to collodion, a layer of which he placed around the furuncle. The result answered to his expectations, for no secondary evil appeared. M. Pasteur discovered the microbe of the furuncle, which he found situated at the summit of the pustule. However, it will be borne in mind that secondary evils do not always depend on auto-inoculation, but often are the result of a diathesis at present not well understood.—*Medical Press and Circular*.

#### Cold Abscess of the Tongue.

A woman, thirty-five years of age, presented herself with a swelling upon

the right side of the tongue. The tumor was the size of a walnut, soft and fluctuating, and not painful on pressure or manipulation. It had appeared, without any known cause, four months previously, had attained its present size in about a month, and then remained stationary. The patient's general health was excellent. Dr. DE BRUN incised the tumor, which gave exit to a quantity of thin pus. The sac was dissected away and the wound closed with sutures. Union was complete in a few days.—*La France Médicale*.

#### Phosphorous in the Treatment of Osteomalacia.

Dr. W. BUSCH reports two cases of osteomalacia treated by phosphorous. The first patient was a fairly healthy-looking woman, thirty years of age, in whom the disease appeared a few weeks after childbirth. The objective signs were confined to the bones of the pelvis. This presented the appearance of having been pressed together from the sides. The symphysis projected forward like a beak, while the horizontal rami of the pubes were sharply bent. Walking was impossible, the patient being able only with the greatest difficulty to move from the bed to a chair. Absolute rest in the horizontal position was ordered to be maintained for three months, and Wegner's phosphorous pills were prescribed. After five months' treatment the patient was able to go up and down stairs without difficulty. At this time she changed her residence and passed from under observation. The second case was that of a woman, fifty years of age, who complained of intense pain in the right arm near the insertion of the deltoid muscle. A diagnosis of osteitis was made and the ordinary measures were prescribed. No improvement was noticed, and after several weeks the pa-

tient abandoned the treatment. In about nine months she again came under observation. She was then reduced almost to a skeleton, was absolutely unable to walk, and was greatly deformed. The dorsal spine was kyphosed, while the cervical spine was so strongly lordosed that the head seemed to rest between the shoulders. The thorax was distorted, the femora were bowed, and the pelvis presented the characteristic deformity of osteomalacia. The patient was confined to the bed for seven months, and took Wegner's pills for a year and a half. At the end of this time the bones were firm, and she could go about without complaint. The deformity was not decreased. The following is the formula for Wegner's pills:  $\mathcal{R}$  Phosphori, 0.025; syr. simpl., 7.5; M. bene et adde pulv. glycyrrh. rad., 10.0; pulv. gummi arab., 5.0; gummi tragacanth., 2.5; ft. pil. No. 250. Each pill contains about  $\frac{1}{60}$  grain of phosphorus. The dose is one pill twice a day, to be gradually increased. Busch does not consider the drug to be of any value in rickets or caries.—*Centralblatt für Klin. Med.*—*Med. Record.*

#### Hot Water in Epistaxis.

M. AUQUIER mentions a case in which he was called to a young man of twenty who had been suffering for three hours from violent epistaxis. The patient had been subject to such attacks from infancy. M. Auquier tried in vain to stop the bleeding by means of cold water, plugging the nares, mustard plasters, &c. At last he irrigated the nose with very hot water, with instant success. During the next night and day the friends of the youth were able by this means to stop at the outset several fresh outbreaks. The author thinks the hot water acted by producing a reflex con-

traction of the bleeding vessels; and not by encouraging the flow, and so causing depletion of the superficial vessels as has been supposed in reference to the stoppage of uterine hemorrhage.—*Gaz. hebdom. de Montpellier.*—*Practitioner.*

#### Extirpation of the Gall Bladder for Chronic Gall-Stones.

From the *Medical Press and Circular*, February, we learn that this operation has been successfully performed by Langenbuch, of Berlin, on the 15th of July, 1882, upon a man, æt. 43, the urgency of whose symptoms justified the risk of the operation. The details of the case were given in the *Berliner Klin. Wochenschrift*, November 27, up to which date the patient's health had steadily improved. Dr. Langenbuch regards this operation as a safe and justifiable one, since it is easy of performance, and the organ removed is not one the existence of which is necessary to life. The steps of the operation are fully described. He recommends it to be performed only by a practised surgical hand, and under the guarantee of the most rigid antiseptics. If very distended, the gall-bladder may be aspirated, thus preventing the chances of rupture and escape of contents into the abdominal cavity.—*Med. and Surg. Reporter.*

#### Spina Bifida.

In the *British Medical Journal*, Mr. ROBSON, referring to the case related by him in a former issue (see p. 415), and in which he had transplanted periosteum from a rabbit, reported that no new bone had been formed, but he thought the periosteum had helped to thicken the spinal coverings. A new principle in the operation was the treatment of the meninges by bringing to-

gether the serous surfaces, after the manner of modern peritoneal surgery. —*Ibid.*

#### A Case of Spina Bifida

Was operated upon by Mr. JESSOP, (*British Medical Journal*) by excising a piece of skin from the top of the tumor, raising the lateral pieces, and then encircling the neck of the unopened sac with a strong catgut ligature and tying it tightly. The sac was then opened and cut away to within less than half an inch of the ligature; its cut edges were accurately approximated by suture, and the lateral skin flaps were then brought together. The wound was treated antiseptically and healed quickly, leaving only a firm scar to mark the site of the tumor. —*Weekly Medical Review.*

#### Sarcoma of the Skin Cured by Arsenic.

KÖBNER reports a case of generalized sarcoma of the skin cured by hypodermic injections of Fowler's solution. This favorable result had continued unaltered nine months after the cessation of the treatment. Altogether the amount of the solution of the potassium arsenite used was 20.75 c. c. (equivalent to 0.23 gm. of arsenious acid). The remedy used for the injections was at first diluted with two parts of water, afterwards with only one; from two and a quarter to nine drops of Fowler's solution were used daily. The fluid was usually injected into the muscles, and principally in the gluteal region. The sarcomatous growths began to dwindle away, showing at first a sinking in of the centre; and coincident with this, some enlarged lymphatic glands which had become prominent, and the swollen liver and spleen, progressively diminished until they resumed their normal size. The

tumors, which at first were of a dark red, became pale, and some of them at the close of the observation had entirely disappeared. —*Berlin Klin. Wochenschrift.* —*Med. News.*

#### A Simple Method of Producing Local Anæsthesia.

Dr. CHEIZE relates (*Moniteur de la Policlinique*) a simple procedure adopted by him in a case of ingrowing toe-nail, requiring immediate operation, at a time when he had no apparatus at hand. He saturated a little piece of lint with ether and placed it on the toe. He then projected the air from an ordinary pair of hand-bellows upon the lint until the ether was evaporated. This was repeated two or three times, when anæsthesia was so complete that the nail was removed without the patient's knowledge. —*N. Y. Med. Journal.*

#### The Destruction of Nasal Polypi by Chromic Acid.

Dr. FRANK DONALDSON (*Med. Record*): The author remarked that the points to be aimed at in the treatment of nasal polypi were their prompt and rapid removal with as little pain and small a loss of blood as possible, and in a manner to prevent their recurrence. He then referred to the three methods ordinarily resorted to for this purpose, and spoke of their advantages and also of their disadvantages. The forceps, the oldest method and most generally employed, is attended with great pain, considerable loss of blood, and often with ulceration of the adjacent structures. It is very effective if the pedicle is removed near its insertion. The sensibility of the mucous membrane can be somewhat diminished by the use of the spray of ice water containing salt, although the mucous membrane cannot be rendered so

insensitive that the use of the forceps will be rendered painless. The advantages of this method are, comparatively short time occupied in the operation and the frequent non-recurrence of the growth. The author then made mention of cutting forceps, snares and other mechanical apparatus for the removal of polypi, directing special attention to Jarvis' completed instrument. According to his experience, however, it is not an easy matter to get hold of the pedicle with any snare, and, according to his experience also, if the snare only is resorted to, the growth almost invariably returns. After speaking of the use of the galvano-cautery, he directed attention to the use of caustics, and stated that they had been abandoned very largely because they frequently injured the adjacent tissue. Glacial acetic acid injected into polypi destroys them, but when it touches the mucous membrane it inflames it and causes great pain, and destroys a part of it, although its irritant properties can be easily neutralized by spraying the part by aqueous solutions. The agent which he had employed most satisfactorily and most successfully was either minute crystals of chromic acid or a solution of one hundred grains to the ounce. It is a powerful escharotic, does not cause pain, its application is not followed by hemorrhage, and when properly used its action can be perfectly controlled. It is also an antiseptic and a disinfectant, more than all the acids or metallic salts which had been tried. Its action is prompt and not penetrating. His mode of application was, first, to moisten the mucous membrane with a lead lotion to protect it, and then taking the paste with a glass rod, very thin and pointed, stick it into the centre of the polypus as far as possible, and by turning the rod wipe off all the acid in the growth itself.

The growth crumbles at once, and is removed without pain and without hemorrhage with the forceps. Sometimes irritation follows the local application, but the lead water, if effectually applied, protects the adjacent structures. After the application of the acid, if it is desirable, the snare can be used with greater precision than before. It can be used in both varieties of gelatinous polypi. In the treatment of fibromata it is valuable, but not to the same degree as in the gelatinous polypus. He wished to be distinctly understood that he did not recommend it to the exclusion of surgical methods, but he had found it effective as an aid to them by destroying the substance of the neoplasm, in making the surgical operation less painful and less bloody, if it was subsequently to be employed, and it was also a very valuable adjuvant as a supplementary application for destroying the insertions of the growth and thus prevent their reformation.

#### Differences in Temperature,

After the use of various antiseptic washes, in a case of emphysema, are given by Dr. RICHARD A. HAYES in the *London Lancet*. During the treatment the following washes were used: 1 per cent. all of eucalyptus, 2 grains; 1 ounce, or less than  $\frac{1}{2}$  per cent. carbolic acid; 2 per cent. boracic acid; and 1 per cent. salicylic acid. A careful record of the morning and evening temperatures showed the following results from the use of the different antiseptics: Oil of eucalyptus (1 per cent.), morning temperature, 98.8° F.; evening temperature, 100.4°. Salicylic acid (1 per cent.), morning temperature, 98.3°; evening temperature, 99.5°. Boracic acid (2 per cent.), morning temperature, 98.2°; evening temperature, 99.4°. Carbolic acid

( $\frac{1}{2}$  per cent.), morning temperature, 97.8°; evening temperature, 98.7°. These temperatures are averages, the periods of observation being carefully selected so as to be free from complicating influences which might affect the fever curve. The results show a marked advantage as regards the hectic obtained by the use of an exceedingly dilute solution of carbolic acid.—*Weekly Med. Review*.

#### The Germicide Value of Certain Therapeutic Agents.

Dr. GEOEGE M. STERNBERG, in the *American Journal of the Medical Sciences*, has made a long series of experimental studies as to the germicide value of certain therapeutic agents on various forms of bacterial organisms. In his experiments on the micrococcus of gonorrhœal pus, he found that, in general, those reagents which destroyed the vitality of the micrococcus from pus are destructive of other organisms of the same class; and their relative value as germicides is not changed when a different micro-organism is used as the test of this value. Moreover, the reagents which were found to be practically valueless as germicides in the first series of experiments, *e. g.*, ferric sulphate, sodium sulphite and hyposulphite, boracic acid, etc., proved to be equally without value when the test was extended to other micro-organisms of the same class. But the reagents found to possess decided germicide power have, in some cases, a different value for different organisms. In other words, the vital resistance of different bacterial organisms to the reagents in question is not in all cases the same. Nevertheless, the comparative germicide value of the reagents tested is the same for the several test-organisms, and, allowing certain limits for specific peculiarities,

it is safe to generalize from the experimental data obtained in the practical use of these reagents as disinfectants. But it must be remembered that the resisting power of reproductive spores is far greater than that of bacterial organisms in active growth (multiplication by fission), and the data obtained for the latter cannot be extended to include the former. The *antiseptic* value of the reagents tested depends upon their power to prevent the multiplication of putrefactive bacteria, and this is not necessarily connected with germicide potency.—*Med. Record*.

#### Ergot in Acute Suppurative Arthritis.

At the recent session of the French Association for the Advancement of Science, Dr. DE MUSGRAVE-CLAY reported a case of suppurative inflammation of the elbow-joint treated with large doses of the fluid extract of ergot, the arm being kept upon a splint. The patient was only six years of age. Rapid diminution of heat, pain, and suppuration ensued, and a recovery with a useful joint rapidly occurred.—*Med. Times*.

#### Extirpation of Bronchocele and its Results

Was the subject of a paper read by Dr. KOCHER, of Berne, at the Twelfth Congress of the German Surgical Society (*Medical Record*). The author remarked that the main difficulties in the operation were the avoidance of injury to the recurrent laryngeal nerve and the arrest of hemorrhage. He thought it best to ligate the veins before the arteries, and in regard to tracheotomy he considered it a harmful procedure, only justifiable in threatened suffocation, as incision of the cartilages tends to increase the bending of the trachea which the lateral pressure of the tumor causes.

He did not think it advisable to remove the whole of the swollen gland, especially during growth, as he thought it would be injurious to the organism, believing that there was some relation between such a radical measure and cretinism or idiocy. Unfavorable results of the operation showed themselves in a feeling of weakness, constant chilliness, slowness of speech, of thought, and of movement, with œdema of the hands, feet, abdomen and especially of the face. The latter gave to the patient the appearance of one suffering from Bright's disease, though there was no albuminuria. Microscopical examination showed a high degree of anæmia. He gave to this group of symptoms the name *cachexia strumipriva*, and he said while the anæmia following extirpation of the spleen was temporary and appeared immediately, this cachexia strumipriva was a progressive pernicious anæmia, and came on sometime after the operation. From this he draws the conclusion that the thyroid gland is a blood-producing organ, or at least aids in the formation of blood. He thought also that it possibly was a regulator of the cerebral circulation. The atrophy of the trachea, which follows the operation, he thought probably due to ligation of the superior and inferior arteries. His conclusions were based on a study of one hundred and two operations.—*Weekly Med. Review*.

#### On Transplantation of Skin-flaps from Distant Parts without Pedicle.

Dr. J. R. WOLFE removes all the cellular tissue from the lower surface of a skin-flap, and then plants it where he desires, and it takes root and grows fast. By this simple procedure we can (he claims) do away with the inconvenient method of allowing the flap to re-

main attached to its original site until it has grown fast in its new home. In the *Practitioner*, he reports good success, and claims for himself priority in recommending this modification.—*Med. and Surg. Reporter*.

### VENEREAL DISEASES.

#### The Difficulty of Detecting True Syphilis in a Woman.

Dr. C. H. F. ROUTH considers the difficulty extremely great. He holds (*Med. Press*) that there is but one true syphilitic and venereal sore capable of contaminating the system, and that the other is a purely local affection, a pseudo-syphilis, chancroid, or dirt sore. This true sore is oftentimes exceedingly minute and benign in appearance and behavior. It may be situated on the cervix uteri, the vulva, or the mammæ, and unless a most careful examination is made, aided by a true history from the patient, its existence is very likely to be overlooked, with the result that we are left in great doubt and uncertainty as to the true nature of the constitutional manifestations which supervene.

#### Hereditary Syphilis in the Production of Idiocy or Dementia.

Dr. J. S. BERRY is led to the conclusion, from experience, that hereditary syphilis is a more frequent factor in the production of mental disturbance than has hitherto been recognized. As a partial explanation of the supposed rarity of the relationship, the following statements may be noticed: (1) That congenital deficiency of mind from inherited syphilis is probably rarer than mental failure coming on in childhood. (2) That the time when this mental failure usually shows itself (namely, near

the second dentition period) is a time when the manifestations of hereditary syphilis are more or less latent; and if the child have not typical teeth or some equally manifest sign, we are not likely, unless the subject is in mind, to think of syphilis. It is, therefore, very important, in all obscure cases of juvenile dementia, to look carefully for all possible indications of specific taint. (3) It is possible, too, that such cases as those related do not often reach idiot asylums, for the dementia is of the inoffensive type and yet not likely to be benefited by treatment.—*Med. Med. Jour.*

#### Treatment of Chordee.

The following prescription has very often been effectual in the hands of M. MAURIAC, in the Hospital des Veneriens: R Syr. digitalis (fr. cod.); syr. morphiae (fr. cod.), āā ʒ iss.; kali bromid., ʒ v. M. Tablespoonful every evening at bedtime. Or a suppository as follows: R Chloral hydrat., gr. xx.; ol. theobromæ, q. s. M. For one suppository. Or the following injection, recommended by Cambillard: R Kali bromid., ʒ iss.; tr. opii, ʒ ss.; glycerinae, ʒ ss.; aq. distill., ʒ v. M. S.: 4 injections daily.—*Med. and Surg. Reporter.*

#### Constitutional Treatment of Syphilis.

W. F. GLENN, M. D., Professor of Anatomy and Venereal Diseases, Medical Department University (Nashville), Tenn.: When a patient presents himself for treatment he should be placed upon the following recipe (which *fully meets all the indications*) until the symptoms disappear, his appetite is improved, and a general feeling of vigor and activity exists: R Hydrarg. bi-chlor., 2 grains; iodia, 6 ounces. M. Sig.: One teaspoonful after each meal.

Iodia contains extracts from the green

roots of stillingia, helonias, saxifraga, and menispermum. Each fluid drachm also contains five grains iod. potass. and three grains phosphate of iron. The tendency of the profession is *too much* towards discarding everything but mercury. I have often seen mercury alone, or combined with iod. potass., *fail to heal* secondary ulcerations, which *speedily disappeared* when combined with vegetable alteratives. It is, therefore, best to have the good effects of the *only three reliable* remedies at once, viz., mercury, iodine, and vegetable alteratives (which is obtained in the above prescription).—*Med. Brief.*

#### Balano-posthitis of Diabetics.

For this trouble Prof. SIMON specially recommends cleanliness, and after each micturition, lotions feebly charged with phenol, and after drying the part, powdering it with the following: R Oxide of zinc, 25 parts; starch, 25 parts; salicylic acid, 1 part. M.—*Med. & Surg. Reporter.*

#### The Treatment of Spermatorrhœa.

Dr. H. COUPLAND TAYLOR thus sensibly writes in the *Brit. Med. Jour.*:

Obstinate cases of spermatorrhœa and frequent nocturnal emissions constantly come under the care of the practitioner. Too frequently the medical man consulted simply tells the patient that if he break off the pernicious habit of masturbation, which has probably originated his malady, he will soon quickly recover. But in fact, in most cases, the habit has already been abandoned before he comes to seek advice; and these cases do not get well for months or even years afterwards unless proper measures be taken. Knowing that he has left off this bad habit, and that he nevertheless does not improve, his com-

plaint being made light by the regular practitioner, and being greatly depressed in mind, he seeks the advice of the quack, who is always ready to benefit by these cases. I will give an outline of the treatment I have followed, and which I have found most successful in several such cases. The treatment should be: 1. Moral; 2. Hygienic; 3. Medicinal. 1. *Moral.* *a.* The pernicious habit of masturbation, which has probably been the origin of the complaint, must at once be discontinued, or no good can result from any treatment. *b.* The thoughts should be directed from himself by his having regular work and exercise. *c.* The anxiety of mind which ensues should be allayed as much as possible and a happy state of mind instituted. 2. *Hygienic.* *a.* The patient should have regular but not excessive mental employment, and bodily exercise in the form of walking, riding, or outdoor sports and games. *b.* Cold sponging of the genitals night and morning for some minutes, or as long as can comfortably be borne, is a most important agent in giving tone to the relaxed organs. *c.* The patient should have a hard mattress, and as little and as light clothing as possible at night. Care should be taken not to lie on the back, which may be prevented by wearing a knotted towel over the spine, or by some other device. *d.* No quantity of liquid should be taken before retiring to rest, and the bladder should be emptied the last thing. 3. *Medicinal.* A mixture containing tincture of perchloride of iron and tincture of nux vomica should be given twice or three times a day; also a pill containing a fourth or a third of a grain of extract of belladonna with three grains of camphor should be given at first every night, and then every other night, immediately before going to bed. If these lines of treatment be adhered to, the

patient, whether suffering from real spermatorrhœa or simply from frequently returning nocturnal emissions, will steadily improve, and the emission will occur less and less frequently, till, in the course of a few weeks, or possibly months—for a malady of long standing (as this usually is) is never cured immediately—they will cease altogether, or only occur at such intervals as may be deemed normal, and in which there is no harm whatever.—*Med. and Surg. Reporter.*

### DISEASES OF THE SKIN.

#### Hypertrophy of Toe Nails.

Before the Midland Medical Society (*British Medical Journal*), Mr. HUGH THOMAS exhibited two very long nails, removed from the great toes of a woman aged sixty-five. They had been allowed to remain uncut for eleven years. The right one measured five inches and a quarter, and passed under the four other toes; the left was three inches and three-quarters in length, and lay over the other toes of the foot. The patient was unable to walk. After removal, the matrix on both sides was found to be healthy.—*Med. and Surg. Reporter.*

#### The Influence of Alcoholism on the Development of Skin Diseases.

JANIN (*Th. de Paris*) says:

1. Alcohol is neither destroyed nor transformed within the organism, but remains there for a considerable length of time, and is eliminated, in great part, if not entirely, by the kidneys, the lungs, and the skin.

2. The bodily disturbances occasioned by this agent consist partly in intense congestion of the organs with which it is chiefly brought in contact, and partly in a profound alteration of the tissues

and more important nutritive functions, which terminates in the development of genuine cachexia.

These disorders produce their most injurious effects on certain organs, particularly the skin, thus making it easy to explain the influence exerted by alcoholism upon the several varieties of cutaneous disease.

3. Alcoholism, by its unaided power, is capable of evoking morbid cutaneous phenomena, whose underlying cause, however, is to be sought for in some special constitutional predisposition, *i. e.*, in either the arthritic, herpetic, scrofulous, or syphilitic diathesis. But these effects are seldom met with; and what we most frequently observe, and should always bear in mind, in respect to this condition, is the important part it performs in the maintenance and aggravation of pre-existing disease, to which it sometimes imparts a very serious character.—*Ibid.*

#### **Tinea Versicolor.**

Tinea versicolor, or *Liver Spots*, is an exceedingly common affection, and one that causes much annoyance, since the patient frets at having this blemish on his skin. To cure it, Dr. GEORGE H. ROHÉ (*Medical Record*) recommends a lotion of hyposulphite of sodium, half a dram to the ounce of water. The patient is directed to take a bath once a day, using soap freely. After the bath the affected spots are to be mopped with the parasiticide lotion. In a week the discoloration has usually disappeared. The remedy should be continued a week or two longer to prevent relapse. Dr. Rohé says it is surprising to what an extent cases of tinea versicolor are treated for syphilis, hepatic derangement, or similar supposed affections of the internal organs. Patients are sometimes compelled

to take mercury or potassium iodide for months, under the supposition that they suffered from syphilis, when the only trouble was that just described, which, when properly treated, yielded to local remedies alone in the brief space of two weeks.—*Ibid.*

#### **Glycerine in Skin Disease.**

M. DESGUIN, of Anvers, has given glycerine internally in certain forms of skin disease with, it is said, marked success, especially in acne punctata and the furuncular diathesis. He commences with four drachms daily and gradually increases the dose. He states that the secretion of the cutaneous glands, which is thick and irritating in these diseases, becomes more liquid, and cutaneous irritation is notably lessened. During convalescence from scarlet fever, he believes that it facilitates desquamation.—*Ibid.*

#### **The Removal of Freckles**

Can be accomplished, according to Dr. J. V. SHOEMAKER, by the careful application of a little ointment of the oleate of copper at bed-time. He makes the ointment by dissolving the oleate of copper in sufficient oleo-palmitic acid to make a mass of the required consistency.—*Weekly Med. Review.*

#### **Cutaneous Absorption, Especially for Lead Salts.**

Dr. L. LEWIN has published in the *Deutsche Medizinische Zeitung* an account of some experiments on the therapeutic value of extended medicinal applications. The author says: Applications to the skin were made at all times of which history gives us record, but only comparatively late did this lead to the methodic use of mercury in the cure of syphilis. The first experimental investi-

gations in regard to the absorption of water and substances dissolved in water were made in the beginning of this century, but led to diametrically opposite results. However, it is established that volatile and corroding substances penetrate the skin and are absorbed. Another way of bringing watery solutions into the circulation is that suggested by Dr. Roehrig, by means of the atomizer. Another method is that suggested by H. Munk, by means of the galvanic current, which according to the author has a future, especially in dermatology, as by it substances can be conveniently brought to a certain depth in and through the skin. The permeability of the cutis is dependent on three factors : 1. The quality of the solvent. 2. The method of application. 3. The condition of the skin. In regard to this last factor there is a great diversity of opinion as to what is normal skin. The author does not consider slight, superficial loss of epidermis as material. His method of demonstrating lead in animal tissues is very delicate and convenient. When albumen or animal substances are boiled with concentrated liquor-soda a yellow solution is formed. If but a trace of lead be present, sulphide of lead is formed as a black precipitate. The conclusions based upon his experiments are, that lead ointments as now in use are pressed through the skin. But this first happens after changes have been produced in the skin by rubbing. After two applications only, he could never discover lead in the tissues, nor by using Hebra's unguentum diachylon repeatedly. A repeated application of a lead solution in the form of spray did not penetrate the skin. The author thinks mechanical force and changes in the skin, such as loss of epidermis or inflammation, necessary for the penetration of lead salts, and says the absorp-

tion of substances, in baths, for instance, is not as simple a matter as has been supposed ; in his opinion water of baths, or substances dissolved in it, are not absorbed.—*Ibid.*

#### The Treatment of Eczema in Prague.

Dr. ROBERT B. MORISON, (*Med. Record*).

For more than a year eczema has been treated in the dermatological wards under Professor Pick in Prague, by the so-called medicated gelatine bandage, and an interesting article on this subject was read by Professor Pick before the Verein deutscher Aertze, January 26, 1883. The difference in treatment of this disease between Vienna and Prague is striking in the extreme. In Vienna there has been no change made since the great Hebra gave the rules which are so universally followed. With the exception of the introduction of naphthol by Kaposi, and which is used only in his wards, tar still holds the chief place in the Vienna treatment of eczema.

Though being far from criticising the excellent results obtained from this agent, I could not but be struck with its uncleanliness and disagreeable odor. As one passes through the wards in Vienna the patients are seen lying upon beds between two blankets, which, from the constant use of tar, have become so impregnated with it that the picture is anything but an agreeable one. Add to this the patient himself, covered often with a thin layer of this dirty-looking mass from head to foot, and one realizes that such treatment can only be used as a *dernier ressort*.

The importance of tar, however, being recognized by every dermatologist, it has been the desire of each one to obtain from it some essential ingredient which they hoped could be used as

effectively and yet do away with its unpleasant application, but unfortunately neither the resinone, or resinin, or carbolic acid, or any of the other products of distillation contain all its virtues.

Even naphthol, so highly praised by Kaposi, and which certainly has some virtues, has not been able to take the place he first hoped it would.

This latter drug is now used almost exclusively in scabies alone, and even in this disease great care must be taken not to produce an inflammation leading to eczema from its universal application. The intensity of inflammation which it sometimes produces, and which far exceeds the application of tar itself, throws it entirely out of the field as a rival of the latter. This is the conclusion which all authors have arrived at after a somewhat prolonged trial since its introduction.

The general laws laid down by Hebra in the treatment of eczema were soothing applications in the acute stage, tar in the dry stage, and macerating applications in the chronic stage.

A patient was powdered with some inert powder until the acute inflammation and moist stage were passed, then tar applied and a cure accomplished.

The amount of labor and nursing required to treat the patient thoroughly according to these rules, to say nothing of the time lost by the patient when in the hospital, where it was necessary he should be, was very great. In chronic cases the time was lengthened so much the more because it was first necessary to render the disease acute by the various macerating applications before the regular treatment could be entered upon. That the results of this treatment, however, were most excellent, could not be denied, but that it left nothing to be desired was far from the opinion of the

author himself, who was always trying to improve upon it.

The efficacious action of tar is generally conceded to be due to the mechanical protection which it affords to the skin and to its antiseptic qualities. There is so much chance for a mycotic appearance to be engrafted upon the moist stage of eczema (e. madidans), that it is one of the strongest arguments for the application of a drug if it has antiparasitic or antiseptic properties. Recognizing to the fullest extent this important property of tar, and being unable to find in any of its derivations a substitute for it, Professor Pick conceived the idea of supplying its place with some other medicine, which also possessed antiparasitic and antiseptic qualities.

For three months I have been studying closely and critically, through the kindness of Professor Pick, his gelatine treatment of this disease, and I have been greatly struck with the simplicity of its application, its cleanliness, and its most excellent results. Instead of the troublesome use of powders and salves, which in Vienna must be applied at least twice a day, the patient in Prague has immediately wrapped over his diseased parts linen bandages smeared with unguentum saponis containing five or ten per cent. salicylic acid. This is applied in any stage and left *in situ* for a week.

After the bandages are applied they are covered with what is known as tri-cot, and which is manufactured, in various sizes and at small expense, especially for Professor Pick, in England. A patient thus dressed is able to go about his work with no inconvenience to himself, and no injury to his clothes. After a week's time he appears at the hospital, the bandage is removed, and the disease examined. If it is found neces-

sary, from the still remaining inflammation and induration, a fresh bandage is applied and left on for another week. Then the gelatine is applied in the following manner: A portion of a mass made by dissolving fifty grammes of the purest gelatine in one hundred grammes of distilled water, and which has been allowed to cool previously, is melted by putting it in a cup and placing the cup in hot water. To this is added the required strength of salicylic acid, usually five per cent. When sufficiently cool this mixture is painted upon the diseased parts with a painter's brush made of bristles, such as is used in applying tar. The layer of gelatine is made about as thick as a sheet of writing-paper, and after it has dried is gently covered with a minimum quantity of glycerine spread on with the hand.

The use of glycerine is found to be necessary to render the gelatine layer pliable and to prevent its contracting, which it otherwise would do with considerable force; sufficient to irritate the skin. It is also worthy of note that it is not practicable to mix the glycerine with the gelatine before it is applied, as it prevents its hardening sufficiently and renders it sticky. It takes a very small quantity only of glycerine, after the gelatine has dried upon the skin, to render it soft and pliable. A few trials teach the nurse the amount required. This use of glycerine obviates the only bad effect which the gelatine can possibly have. With such a gelatine bandage a patient seldom feels the slightest itching, the diseased parts are seen through the transparent layer, thus rendering the progress of the disease visible without the removal of the application, and, what is much more agreeable to the patient, an ordinary bath removes all traces of it. So easy is this method of treatment that the patient can make his own

applications in most cases, and there is no fear of a too strong action to be produced by the drug. In many cases of chronic eczema the application of this medicated gelatine is made immediately without the previous use of the above-mentioned linen bandages. Also in acute eczema, especially in *crusta lactea*, this rule may often be followed. There is no reason why the medicated gelatine should not be immediately applied in any cases of eczema at any stage; but experience has shown that salicylic acid first applied in the moist stage of acute eczema in the form of salicylated soap ointment for a period long enough to reduce the inflammation, renders the use of medicated gelatine more prompt in its results.

In trying this treatment, there are a few points in the method of application which it is necessary to insist upon.

The salicylic acid must be thoroughly well mixed with the soap ointment whilst warm, and this must be spread, when at about the consistency of butter, evenly upon short linen bandages, which should not be more than one and a half inch in width, and even much narrower when applied to fingers or toes. The ointment should not be in a thicker layer than the back of an ordinary table-knife, and should be spread fresh every time it is used. It is well not to mix up too large a quantity of the ointment, as upon standing it hardens and is more difficult of application.

The gelatine should be prepared by dissolving in distilled water and heated in a porcelain crucible. After stirring thoroughly it is allowed to cool, and forms a cake, which takes the form of the crucible. This cake can be kept for any length of time in paper, and the necessary quantity broken off every time it is to be used.

The salicylic acid must be kept sepa-

rate from it, and only added to the gelatine when it is melted. The mixture should not be painted upon the skin unevenly or in a thick layer. When properly applied it can be torn from the skin in quite large pieces, and it comes off without pain to the patient, or irritation to the disease. It sounds like the tearing of tissue paper, and when thus torn off looks as if the patient was having his epidermis removed by force.

Any holes or rents in the gelatine covering may be repaired from time to time by a fresh application. The indications for the renewal of the whole covering are when it has worn off or after a bath.

After having seen as many as a hundred cases of eczema treated by this method, I consider it fully equals the old tar treatment in the results obtained, and that it far surpasses it in the simplicity of its application and in its cleanliness, a quality which recommends it immediately to the patient.

#### The Removal of Warts.

Warts may be removed by cauterization, as recommended by Dr. CELLIER in the *Journal de Méd. et de Chir. Pratiques (Medical Record)*. An ordinary pin is thrust through the base of the wart, care being taken not to wound the healthy tissue beneath. Then, the skin being protected, the head of the pin is heated in the flame of a candle. It is said that the wart becomes white and fissured in a few minutes, and comes away on the point of the pin. Dr. Cellier also says, that it is only necessary to remove one wart on the hand, that though there may be a dozen, all the others will disappear without treatment.—*Ibid.*

#### Salicylic Hair Tonic.

A correspondent of the *Druggists' Circular* recommends the following as

the best remedy against dandruff, itching of the scalp and falling of the hair: Borate of soda, 10 drachms; salicylic acid, 10 scruples; tincture of cantharides, 6 ounces; bay rum, 25 ounces; rose water, 25 ounces; boiling water, enough to make 4½ pints. Dissolve the borax and the acid in boiling water; mix the bay rum and rose water with the solution; then add the rest, and filter.

#### Chlorate of Potassium in Ulcerating Epitheliomata,

In fine powder, is said to yield excellent results when dusted over the surface of ulcers and ulcerating epitheliomata. The surface should be cleansed and the powder dusted thickly on twice a day. This, it is claimed, relieves pain and promotes healing.—*N. Y. Med. Journal.*

#### On Affections of Mucous Membranes in Lichen Ruber Vel Planus.

In a series of cases of lichen planus, studied by CROCKER (*Monatsheft für prak. Dermatologie*), were found white streaks and spots on the tongue, and also on the inside of the cheeks. They were scarcely above the level of the surface, and gave no pain or annoyance. No parasite was discovered. These spots and streaks are believed to be of diagnostic value, as they sometimes precede the skin-eruption by several weeks, and may remain after it has disappeared.—*Centralblatt für Chirurgie.*—*Med. Times.*

#### DISEASES OF THE EYE AND EAR.

##### Optic Decussation.

From a series of experiments on cats, by removing one eye and tearing across the optic nerve on the same side, a few days after birth, and allowing the ani-

mal to grow up, GAUSER concludes as follows: 1. The animal can only see with the temporal half of the remaining eye. 2. Such loss of vision interferes with psychical development of the animal even more than the removal of a large portion of a hemisphere. 3. In the cat the course of the uncrossed nerve fibres is along the lateral side of the nerve and chiasm, while they enter only through the outer portion of the scleral opening, going only to the temporal half of the retina. 4. Such injuries as the above hinder the development of the outer corpus geniculatum and the anterior corpus quadrigeminum on the same side, but do not affect the growth of the hemispheres.—*Archiv. f. Psychiat. —Weekly Med. Review.*

#### Dry Antiseptic Treatment of Chronic Purulent Otitis.

Dr. CHARLES H. BURNETT gives the results, in the Polyclinic, of his treatment of twenty-four cases of purulent discharge from the ear. The means employed were applications of dry antiseptic powders. Two powders were used, twenty-one cases being treated with one compound of three parts of boracic acid, finely powdered, to one part of tincture of calendula officinalis, the alcohol evaporated from the mixture and the mass re-powdered; and three with the other, which was compound of resorcin one part and boracic acid eight parts. In all instances absorbent cotton was used to mop the moisture from the ear, the syringe being used in only a few cases, in order to insure the necessary cleansing, which could not in these exceptional cases be accomplished without it. The result of such treatment was eminently satisfactory.—*Med. Age.*

#### The Examination of Ears by Means of the Tuning-Fork.

EMERSON (*Arch. of Otology*, xii, 1), after an examination of a large number of persons with normal hearing, draws the following conclusions: 1. Reliance on the statements of patients in regard to the loudness of tuning-forks, as a test in ear troubles, will lead to error, unless account is taken of the fork used. As a rule, in normal ears high notes are heard louder through aërial conduction, and low notes louder through bone-conduction. This is true also, to a limited extent, in diseased ears. 2. The relative duration of aërial and bone-conduction is a better test. In normal ears, in all cases, the tuning-fork is heard longer through air than through bone, the proportion being greater for high than low notes; and for the middle C (c') it should be heard about twice as long through air as through bone. Any marked departure from this indicates disease. 3. In external, or middle-ear disease, this proportion is reduced, and in well-marked cases, the average bone-conduction remaining the same or being increased, the aërial conduction will be reduced until it becomes equal to or much less than bone conduction. 4. When the bone-conduction is longer than aërial conduction, and yet much less than the average duration of bone-conduction for normal ears, it is an indication not only of middle-ear troubles, but that the nervous apparatus is involved. 5. If the proportion between bone and air remain the same, and the hearing power be much lowered, it is probably an indication of disease of the internal ear. Air-conduction markedly exceeding bone-conduction, the bone-conduction may be entirely lost, and yet air conduction continue to a limited extent.

# **FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.**

## **A Case of Dislocation of Cervical Vertebrae.**

Dr. WILLIAM L. AXFORD (*Annals of Anat. and Surg.*):

Katy Collins, æt. 8, fell Sunday, April 15, striking her forehead on the sidewalk. A bruise, disappearing after a few days, was noticed by the mother, but, as nothing alarming followed, she was allowed to go about her play as usual. Six days later the mother noticed that her head was bent forward, and that her chin could not be raised any great distance from the sternum. Supposing it was a "stiff neck," little attention was paid to it; but, becoming alarmed at its persistency, the mother brought the child to me at the South Side Dispensary. Her general health was fair, the only complaint being a tired feeling in the neck, which was relieved by placing both her hands on top of her head and bearing down. Inspection showed a deep furrow between the muscles on either side of the spine, beginning at the level of the upper surface of the fifth cervical vertebra and extending upwards. The head was pushed directly forward, motions much limited, particularly extension. On tracing the spinous processes upwards a marked break was evident at the level of the upper surface of the fifth cervical, the spinous process of the fourth being fully two-thirds of an inch in advance of the one below it, while a break in the continuity of the transverse processes could be easily felt on each side. With the finger in the pharynx, the projecting vertebra could be readily determined. There was not then, nor had there been at any time, so far as I could learn, any symptoms of involvement of the cord, the child, with the exception

of the awkward position of the head, being as well as ever.

This was evidently a case of bilateral dislocation forward of the fourth on the fifth cervical vertebra. Prof. E. Andrews confirmed the diagnosis. Eleven days having elapsed since the accident, with no symptoms calling for interference, I made no effort at replacement.

Prof. Andrews suggested rest in bed with moderate traction, hoping to better the position of the head, but, owing to a misunderstanding with the instrument-maker, this was not carried out. June 13, in company with Dr. J. G. Kiernan, I last saw the case. She is in much the same condition, so far as general health is concerned, but the head is much more erect, owing to an increase in the lumbar curve, no apparent change having taken place at the point of dislocation. We again estimated the amount of displacement to be fully two-thirds of an inch. The manner in which so marked a displacement of the vertebrae could occur, with no symptoms of injury to the cord, has been the subject of considerable speculation on my part, and I am forced to believe that the fall on the forehead first produced fracture, probably of the articular processes, followed by a dislocation as the result of muscular contraction. In favor of this view I would submit the following:

1. In the majority of cases of dislocation of the vertebrae fracture co-exists, some surgeons denying the possibility of dislocation without fracture. However, that a simple dislocation may occur, especially in the cervical region, is highly probable. See Dr. Williams' case, *British Medical Journal*, April 7, 1883.)

2. From the direction of the force it would be natural to expect that, had dislocation occurred at once, it would have been a dislocation backwards.

3. So awkward and unnatural a position of the head could scarcely have escaped the attention of the mother when examining the bruise on the child's forehead.

4. Examination of the relations of the fourth to the fifth cervical vertebra has convinced me that a dislocation forwards, to the extent which I believe to be present in this case, could not occur abruptly without injury to the cord. On the contrary, if the displacement was gradual, accompanied by a tilting upwards of the spinous process of the upper bone, there would be much more probability of the cord escaping injury. That the cord is capable of accommodation to a certain extent is shown in some cases of Potts' disease with marked curvature.

#### Resection of the Wrist.

From a careful study of upward of sixty cases of resection of the wrist, Dr. G. NEPVEU is not led to think very highly of the operation as regards either the cure of the disease or the restoration of function of the joint (*Revue de Chirurgie*). The following conclusions are formulated by him: 1. Resection of the wrist is not usually dangerous to life, especially when performed under antiseptic precautions. 2. A good result is sometimes obtained in the cure of the local disease and restoration of function. 3. This is, however, rare, occurring in not more than one-fourth of the cases. More frequently the cure of the disease is incomplete and the restoration of function but partial. 4. A more grave termination is not uncommon; sometimes death ensues, and sometimes, owing to non-arrest of the disease, amputation is required. 5. One cause of this want of success in resections of the wrist is, that the operation is often undertaken in unfavorable cases.

The operation is contra-indicated in osteitis and in synovitis with tubercular deposits. 6. To obtain the best results as regards the usefulness of the joint, as little as possible of the bone should be removed and the periosteum should be preserved as far as the conditions of the case will permit. 7. An operation should never be had recourse to until all conservative therapeutical measures have proved unavailing. Such measures are immobilization, compression, counter-irritation, prolonged antiseptic lotions, &c.—*Med. Record*.

#### To Control Hemorrhage in Hip-joint Amputation.

The abdominal tourniquet is a cumbersome apparatus, and we hail with pleasure the following ingenious device of Dr. JORDAN LLOYD (*Lancet*).

A strip of black India-rubber bandage, about two yards long, is to be doubled and passed between the thighs, its centre lying between the tuber ischii of the side to be operated on and the anus. A common calico thigh roller must next be laid lengthwise over the external iliac artery. The ends of the rubber are now to be firmly and steadily drawn in a direction upwards and outwards, one in front and one behind, to a point above the centre of the iliac crest of the same side. They must be pulled tight enough to check pulsation in the femoral artery. The front part of the band passing across the compress occludes the external iliac, and runs parallel to and above Poupart's ligament. The back half of the band runs across the great sacro-sciatic notch, and, by compressing the vessels passing through it, prevents bleeding from the branches of the internal iliac artery. The ends of the bandage thus tightened must be held by the hand of an assistant, placed just above the centre of the iliac crest, the

back of the hand being against the surface of the patient's body. It is a good plan to pass the elastic over a slip of wood held in the palm of the hand, so as to diminish the pain attending the prolonged pressure of the rubber bandage. In this way an elastic tourniquet is made to encircle one of the innominate bones, checking the whole blood supply to the lower extremity.—*Med. & Surg. Reporter*.

#### Trichlorphenol.

DIAWIN has used in many cases of gangrene and ulcers, as well as recent wounds, trichlorphenol in five per cent. solution as a wash and one per cent. for permanent dressing. (*Petersburger Med. Wochenschrift*, 1883, No. 38.) For cleaning gangrenous parts and setting up healthy granulations, four to six days are usually sufficient. Sometimes trichlorphenol in powder was applied and allowed to remain on the wound for from five to eight days. The author formulates his results as follows: Trichlorphenol possesses twenty-five times the disinfecting property of carbolic acid. Minimal quantities destroy fermentation in wine, urine and blood. As an antiseptic it, with its salts, excels all of the usual antiseptics, as hypermanganate salts, chloride of lime, carbolic, salicylic and boracic acids, thymol, etc., and in addition to its disinfecting properties it is a potent deodorizer. The peculiar odor of trichlorphenol is entirely removed by the addition of oil of lavender (five drops to 30.0 grm.). When used in substance it exhibits a slightly caustic action. In solution, however, it does not irritate in the least degree. So far it has not appeared whether any general symptoms occur after resorption takes place. In this respect further experiments are awaited with interest.—*Ibid.*

#### Treatment of Ulcers with Bismuth.

Dr. TRUCKENBROD reports a number of cases of varicose and other ulcers of the leg cured by the local application of subnitrate of bismuth. The cases were seen at the Wurzburg Polyclinic. The bismuth in fine powder was dusted over the ulcer until a thin layer was formed, and then a simple roller bandage was applied; where there were varicose veins a rubber bandage was employed. The ulcers were usually healed in a few days. (*Centralblatt für Klinische Medizin.*)—*Med. Record*.

#### Iodoform in Toothache.

SCHAFF recommends iodoform on account of its gently caustic action as an anodyne application to exposed tooth-nerves (*Deutsch. Med. Zeit.*, No. 12). The circumstance that a single or repeated application of iodoform does not produce any irritation, much less any inflammation of the periosteum, and the double function of the remedy as a cleansing and disinfecting agent make it especially appropriate as a caustic, particularly before the introduction of a temporary filling. The author uses a paste consisting of iodoform powder, gr. 60; kaolin, gr. 60; carbolic acid, gr. 8; glycerine, q. s.; oil of peppermint, gtt. 10. Triturate the iodoform, kaolin and oil of peppermint with enough glycerine to form a thick paste.—*Weekly Med. Review*.

#### Acetate of Aluminum.

PINNER has given the result of two years' use of acetate of aluminum in the Freiburg clinic (*Ztschft. f. Chirurgie*). The number of operations was 708, including 119 tracheotomies. The treatment by the acetate yielded better results than the typical Lister dressing.

Only six cases showed any symptoms of erysipelas, and only one died. This certainly makes an excellent showing for the dressing.—*Weekly Med. Review.*

#### Submucous Chloroform Injections in Toothache.

*Gaillard's Med. Jour.* says that Dr. GUILLOT (*Progrès Médical*) claims to have had very good results in the treatment of toothache from the injection of chloroform beneath the mucous membrane of the gums. The effects are more immediate and lasting than those of morphine. There have been no resultant abscesses or inflammations.—*Med. and Surg. Reporter.*

#### Hysterical Contracture and Paralysis.

HUCHARD entirely relieved an hysterical contracture of the forearm by the application of an elastic bandage.—*Revue de la Thérapeutique.*—*Med. Times.*

#### Local Nature of Malignant Growths.

According to HUTCHINSON, inflammatory processes may pass by almost insensible gradations into those of malignancy. A local senility—a premature old age of the tissues concerned—is almost always necessary to the production of cancer, the exceptions occurring in cases due to inheritance. Tissues and organs just passing out of use are most prone to develop cancer. Inheritance does not necessitate constitutionality. Not germs, not a blood-disease, are inherited, but a peculiarity of cell structure, which permits with greater ease the injurious influences of local causes. The treatment of cancer should be preventive—removal of the growth before malignancy has developed and before the lymphatics are affected.—*Brit. Med. Journ.*—*Med. Med. Journal.*

#### The Latest Remedy for Cancer.

Finely powdered ergot has been used with great benefit by Dr. W. A. COLLINS (*Cin. Lancet and Clinic*) in all cancerous ulcerations. The powdered ergot is applied three times a day to the surface of the ulcer. After each application a muslin rag wet with carbolic acid lotion is applied. The doctor claims to have had unlooked-for results from its use.—*Ibid.*

#### Gastric Cancer.

Prof. TYSON (*Med. News*) thus closes a clinical lecture:

The question of *treatment* is an important one. For although it is impossible to do anything to remove the growth, we should not at the same time be apathetic in the matter, and I am quite sure that a good deal more can be done than is commonly thought possible. As a rule, the food taken into the stomach is sooner or later rejected; but this is partly because the stomach is disqualified to prepare it; to reduce it, by digestion, to the liquid state, it must have to enable it to pass through the pylorus. Now, if we can digest the food partially or altogether before it is put into the stomach, we obviate this difficulty. Still better will we accomplish our purpose if we can introduce it partially or wholly digested into the rectum.

The stomach has no use outside of the preparation of the food for digestion. It is not a vital organ in the sense that the heart and the lungs are vital organs. It is important so far as it prepares the food, but if the food can be prepared for absorption outside of the body, its necessity is diminished, as it also is, if we introduce this artificially digested food into the rectum. Or we may use both of these methods. We can, by the use of prepared food, di-

minish the labor of the stomach, and, by using the prepared food by the rectum, we can relieve the stomach of all labor. This is being done of late by peptonized foods of various kinds. The food may be prepared by the *extractum pancreatis*, which is now made by a number of pharmacists. Three to five grains of the extract added to a pint of milk, and placed at a temperature of  $100^{\circ}$ , will in one hour peptonize all the casein. A curd is first produced, which subsequently undergoes digestion. The addition of rennet will, then, not produce coagulation. Milk thus prepared makes little demand upon the stomach for digestion, and it can be introduced by the rectum with good effect. The peptonized milk has a peculiar bitter taste, and, unless this bitterness is present, the digestion is unaccomplished. The digestion will take place at a lower temperature than  $100^{\circ}$ , but it takes longer.

I have had very satisfactory results from another method of preparing the food for use by enema, the only objection to it is that it is a little troublesome. I saw it suggested in 1876, but by whom I cannot now recall, and I have since frequently used it when the patient is to be maintained solely by enema. The plan is to take from one and a half to two pounds of beef, with the fat removed, and from one-half to one pound of fresh pancreas. The pancreas is finely chopped and afterwards bruised in a mortar with tepid water of a temperature of  $100^{\circ}$ . It is then strained through a cloth. The juice obtained is intimately mixed with the meat, which has previously been chopped into small pieces. The product is next allowed to stand at a temperature of  $100^{\circ}$  for two hours; it is then ready for use. This amount suffices for two daily injections. The preparation de-

composes very quickly, so that it has to be made fresh every day. I was surprised at what I had accomplished by this method. In the man with the dilated stomach, to whom I have referred, nothing could pass the pylorus, but during the use of daily enemata there occurred each morning an evacuation from the bowel as natural as though the patient were living on a mixed diet and digesting it properly. The extract of pancreas will probably answer as well as the method which I have described, but I have not had any experience with it.

In this connection, I want to call your attention to a little book, by Dr. William Roberts, *On the Digestive Ferments and the Preparation and Use of Artificially Digested Food*. After an account of normal digestion, he gives a description of the methods of preparing food by the use of these ferments. The method which I have just given you is not contained in this book.

The use of peptonized food is advantageous in many diseases, and especially in the diseases of children. Most cases of diarrhœa in children are due to indigestion, but by means of the extract of pancreas we have the power to prepare the food for absorption, thus lessening the labor of the stomach. The so-called *liquor pancreaticus* may be used for the same purpose, but I have had more experience with the extract.

By using this method of alimentation we can, in cancer of the stomach, prolong the life of the patient and make his condition less burdensome. But it occasionally happens that rectal alimentation does not appease the sense of hunger; and I have had patients who, in spite of all injunctions to the contrary, and who, knowing themselves that they would sooner or later reject it, would take food by the mouth.

It has been proven over and over that life can be sustained in this way. Not only have dogs been kept alive for months by rectal alimentation, but the same thing has been done with men. But where it is possible the stomach should be made use of to some extent and thus save the rectum.

#### **Inguinal Hernia.**

Dr. VANCE, of Cleveland, O., in the first paper read before the Surgical Section of the American Medical Association, alluded to the causes of oblique inguinal hernia, and adduced the evidence presented by a case then under his care at Charity Hospital, as showing the influence of the transversalis fascia in the etiology and cure of rupture. This patient, a few years since, had double inguinal hernia; trusses that kept the protrusions in place were worn until some eighteen months ago, when accident revealed the fact that the hernia on the left side no longer existed. Examination demonstrated a wide external opening and a patent inguinal canal—yet the internal opening had closed, and in this way the rupture on the left side was cured. Dr. Vance spoke of cases that he had operated upon by Dowell's plan—where the canal was closed by drawing its anterior and posterior walls together and uniting the pillars of the external opening—yet in which the hernia reprotruded seemingly from failure to effectually obliterate the internal opening. To accomplish the latter end he proposes a method that seems feasible; a semicircular needle is introduced subcutaneously, and a suture is carried across the internal ring in such manner that its inner and upper segment is forced outward and downward into contact with its outer and lower segment, thus converting the inner ring into an

oblique slit. This suture is below the level of the aponeurosis of the external oblique, and its two strands pass through the same canal until the level of the transversalis fascia is reached. Its effect is not only to bring together the borders of the opening and convert the internal ring into a slit, but its pressure causes the peritoneal surfaces to unite, thus permanently approximating the formerly separated folds of the transversalis fascia between which the hernia protruded; while, by the removal of the influence of the extruded mass from the neck of the sac, the adventitious tissue that surrounds that part is enabled to contract and in time permanently obliterate the passageway from peritoneal cavity to inguinal canal. With slight variations, the other steps of his procedure are closely akin to those introduced by Dowell. By tightening the sutures Vance claims the internal ring is closed, the walls of the inguinal canal approximated, and the pillars of the external opening brought together in such manner that what was the avenue for the exit of the hernia is converted into a valve sufficiently strong to prevent reprotrusion for the time being, and that when the strands are removed such changes have been produced in these parts that the hernia is permanently cured. The method is on trial, and unless the value is impaired by some as yet unforeseen complication, Vance is hopeful it will prove of permanent utility, in the treatment especially of oblique inguinal hernia.

#### **Morphia in Strangulated Hernia.**

The reduction of strangulated hernia by the subcutaneous injection of morphia first employed by Dr. PHILLIPPE, of St. Maudé, may render excellent services. Consequently many practitioners in the country, where either the want of proper

instruments or the prejudice or unwillingness of the peasants to submit to an operation are serious obstacles to be got over, adopt this method in almost every case, and rightly so, as the effects are sometimes marvelous. A country surgeon has just published a report of eight cases treated thus by him with only two failures. The taxis and all ordinary means failed, and colotomy seemed the only resource. Twice the reduction was impossible, and the patients having refused to be operated upon would have infallibly succumbed. In one case to which he was called everything was ready for the operation, the patient consenting, when he proposed to inject a quarter of a grain of morphia over the strangulation. A quarter of an hour afterward the hernia was reduced without difficulty. Sometimes the delay is longer, but the pain and vomiting ceases; hence the operation can be postponed without fear for some hours, when a new injection is made and often succeeds.—*Med. Record.*

#### The Local Origin of Malignant Growths.

MR. JONATHAN HUTCHINSON, in the *British Medical Journal*, contributes a paper on the nature and scope of the local influences which induce malignant action. "The more we investigate the more clearly will we see that all inflammations are really infective, and that inflammatory processes may pass by almost insensible gradations into those of malignancy." It is not so much senility of the entire organism as local senility (an old age of the tissues concerned, which is premature, and does not correspond with that of the body as a whole) that is almost always necessary to the production of cancer, exceptions occurring, however, in cases due to the influence of inheritance. Tissues and organs which are just passing out of use are

those most prone to develop cancer. As to the inheritance of cancer, it has been urged that a disease which is capable of inheritance must be a constitutional one. This is true to some extent; but Mr. Hutchinson says that a peculiarity of cell-structure generally is inherited, not germs, not a blood malady, but a special type of cell-organization, permitting with greater ease than in other persons the injurious influences of local causes. The rodent ulcer of the face is looked upon by the author as a form of morbid action which stands half-way between common inflammation and cancer. There is also a distinct proneness possessed by parts formerly affected by syphilitic inflammation to become affected by some malignant growth. In conclusion, Mr. Hutchinson urges the adoption of his doctrine of a pre-cancerous stage, where surgical interference is necessary and ought to be insisted on, before the growth takes on any definite form except that resembling ordinary inflammation, and before the neighboring lymphatics are affected. Without this, he sees no hope of any improvement in the reduction of the mortality of cancer.—*Med. Record.*

#### How to Cure a Felon.

DR. J. M. HOLE (*Peoria Med. Monthly*). We have seen in various medical journals, at different times, how to cure felons. We have never seen our cure published, and will give anybody fifty dollars who will try our cure and it fails. Well, so far so good. Now for the cure:

Take common salt, roast it on a hot stove until all the chlorine gas is thrown off, or it is all dry as you can make it. Take a teaspoonful, and also a teaspoonful of pulverized Castile soap, add a teaspoonful of Venice turpentine, mix them well into a poultice and apply to

the felon. If you have ten felons at once, make as many poultices. Renew this poultice twice a day. In four or five days your felon will, if not opened before your poultice is first put on, present a hole down to the bone where the pent up matter was before your poultice brought it out. If the felon has been cut open, or opened itself, or is about to take off the finger to the first joint, no matter, put on your poultice, it will stop it right there, and in time your finger will get well, even if one of the first bones is gone. Of course, it will not restore the lost bone, but it will get well soon.

#### **Surgical Expedients in Emergencies.**

Dr. R. J. LEVIE (*Polyclinic*): The necessity for evacuating an over-distended bladder is liable to become immediately urgent on occasions when a catheter is not quickly attainable. It is remarkable how often the condition is overlooked by practitioners, until it becomes one of suffering and danger, demanding instant relief. The continued dribbling that often occurs from an almost bursting bladder may mislead or blind one to the grave danger. The absence of a catheter on one such pressing occasion led me to contrive a ready means of evacuating the urine. The recourse was to a piece of iron bell wire, bent double on itself, and the blunt double end passed readily through the urethral tract to the bladder. The distention of the urethra by the doubled wire allowed the urine to freely pass between the wires.

A female catheter may be extemporized from a short piece of rye straw, the end of which is to be closely wrapped for a short distance with thread; or the end of the straw may have its sharpness removed by dipping into melted sealing wax. The stem of the ordinary clay

tobacco pipe is also efficient for the purpose. Such crude substitutes, when oiled, are readily introduced.

The operation of venesection would probably be more frequently resorted to when needed, if a proper lancet, in perfect order, were at hand; but the critical time for relief of an actively congested or inflamed lung or brain is sometimes allowed to pass, for want of a ready and certain method of opening a vein. I once, on a pressing occasion, bled a patient at the bend of the elbow, with perfect ease and precision, with but a blunt-pointed and dull pocket-knife, by resorting to a simple, convenient expedient. Having put on the usual constricting bandages to distend the veins, I first transfixed the most prominent vein with a fine needle. Thus held securely, it was very easy, with even the dull knife, to cut a valvular incision into the vein, and the blood flowed freely.

For the arrest of nasal hemorrhage I know of no device so good as one that may be readily extemporized with a strong piece of cord and some small pieces of sponge. The cord is tied securely to a piece of sponge, cut rounded, and just large enough to be forced backwards through the nostril. Then a number of similar pieces of sponge, with a hole through the centre of each, are threaded successively on the cord. The sponge on the end of the cord is then pushed, with a probe or dressing forceps, through the nostril, quite back to the faucial orifice; and the rest of the threaded pieces of sponge are slid back, one at a time, until the nares is tightly filled. When the patient becomes secure against a repetition of hemorrhage the plugging is readily removed, one piece of sponge being withdrawn at a time, with the dressing forceps. The posterior nares may also be easily

plugged by introducing either a slender gum bougie or a piece of thick catgut string, with a cord attached, through the nares, catching one end of it in the fauces with forceps, and drawing it forward through the mouth. To the cord which follows, a piece of sponge or pledget of lint is tied, to be drawn up into the posterior nares.

A method of making unirritating and painless pressure within the nares, in cases of obstinate epistaxis, is by a piece of the intestine of a chicken or other small animal, about twelve inches long, partially filled with either air or water. One end of the intestine is, while empty and collapsed, pushed backward through the nares; when thus lodged, the air or water in the other end is forced, by compression with the hand from the pendulous portion, into the part lodged in the nares. Strong, equable compression can thus be made, rendering hemorrhage impossible.

In a case of hemorrhage from the intercostal artery, from homicidal stabbing, I arrested the flow immediately by making pressure within the pleural cavity, directly on the vessel, by introducing into the wound the handle of a door-key. The key was then turned transversely, so as to make direct pressure, and maintained in that position for some hours, until there was no more tendency to hemorrhage. The same mechanical action might be effected by the similar use of the handle of an ordinary gimlet.

As a very efficient substitute for Es-march's elastic bandage, I suggested, some years ago, in an article in the *Philadelphia Medical Times*, the use of a bandage made from an ordinary flannel, cut bias, so as to increase its elasticity. Such an elastic bandage, from a material almost everywhere at hand, is, I know from experience, perfectly effective.

The hæmostatic action of hot water does not seem to be sufficiently known and appreciated among practitioners. It is so effective, and can be so readily applied, that it may well displace from practice all other hæmostatics. Water at a temperature not beyond tolerance of the immersion of the hand in it, which is a temperature of from one hundred and fifteen to one hundred and twenty degrees, is ordinarily all that is necessary; but in some cases not amenable to treatment by the ligature, a temperature above 160° F., the coagulating point of albumen, may be necessary.

The absence of a tenaculum may be well replaced by a small fish-hook secured to a pen-holder.

For dislodging a foreign body in the œsophagus by forcing it downward, an ordinary carriage or riding whip, knotted far enough from the end to insure the proper degree of flexibility, may be an efficient expedient in an emergency.

Materials for splints for the temporary dressing of fractures can be at almost all times extemporized from the materials of wooden boxes and binders' boards. To dress fracture of the forearm and of the leg, in a case required to be removed to a distance from the scene of the accident, I once improvised an efficient dressing by breaking into strips some ordinary palm-leaf fans, which were at hand, and bound them on the limbs. I commend the material for its merits of being elastic and comfortable to the shape of the limb. Good temporary dressings can also be made from common straw, cut to proper length and bound in layers on the limb.

For a readily made fixed dressing a plan I have resorted to is with ordinary sand-paper as the material. The sand-paper is dipped into warm water, to soften the paper and glue, and it is then applied and retained with a bandage.

The glue of the sand-paper soon gives rigidity; body and firmness are produced by the sand and paper. Strong fixed dressings, it should be remembered, can be readily prepared with the familiar domestic commodities of starch, or with the combination of eggs and flour.

In removing a patient with a fractured thigh or leg, the uninjured limb can be made to temporarily act as a splint and take care of the injured one, by simply bandaging the limbs together. It should be borne in mind that many fractures of the long bones can be well treated without any kind of splints. Fractures of the femur are not now generally treated with splints. After coaptation is effected, simple extension, by means of weights, is the only essential. Fractures of the clavicle are, I am convinced, from practical experience and much attention to the subject, the most effectively treated by keeping the patient in the supine position of the body, with the head alone slightly elevated, to relax the sterno-mastoid muscle, one of the factors of displacement of the fragments. If this position, on a level mattress, is maintained for only a week or ten days, the tendency to displacement is so overcome that a mere sling for support of the arm and shoulder, or other simple dressing, is all that is necessary.

The simple postural method of treatment, without splints, is applicable to most fractures in the vicinity of joints. In fractures of the upper end of the humerus, splints are usually of no real practical advantage, and the injury can be well treated by position of the arm, and by support against the thorax, maintained by adhesive strips, or bandages, occasionally aided by an axillary pad.

#### **Nervous Symptoms of Exophthalmic Goitre.**

In summing up an admirable article upon some troubles dependent upon the

central nervous system observed in patients affected with exophthalmic goitre, Dr. G. BALLEZ, after reporting some clinical cases, draws the following conclusions: 1. To the classical symptoms of exophthalmic goitre (over-action of heart, exophthalmia, goitre, trembling) there are quite often added others which, like those already mentioned, belong to a perturbation of the nervous system. 2. These symptoms are *convulsive* (epileptic or epileptiform) or *paralytic* (either hemiplegic or paraplegic); finally, in some instances, apparently quite often, there is, besides, *albuminuria*, *glycosuria*, or simple *polyuria*. 3. These convulsive or paralytic symptoms appear to belong not directly to Basedow's disease, but to another neurosis coincident with this (epilepsy, hysteria, etc.). 4. Certain convulsive phenomena (epileptic attacks), however, appear to be connected closely with the goitre itself. And the special clinical conditions under which they appear warrant the opinion that they are due to a cerebro-bulbar circulatory trouble, occasioned by the increased action of the heart. 5. For the rest, among the paralytic disorders, there are some which are light, such as weakness of the hands, or want of power, often transitory, of one or both superior extremities, or feebleness of the lower extremities, which may be directly attributed to the malady of Graves, whether it be merely a trembling of the extremities or more marked symptoms the result of transitory modifications in the cerebral circulation. 6. The polyuria, albuminuria, and glycosuria are probably much more frequent than has been supposed, and probably indicate trouble of the innervation of the bulb. 7. The malady of Graves appears to be simply one of those numerous symptomatic conditions by which a "nervous diathesis" is manifested; a symptom-complex

which sometimes occurs isolated, at other times combined with other manifestations (epilepsy, hysteria, chorea). 8. There are grounds, however, for asking, in referring to certain facts clinical (Féréol) and experimental (Filehne), if certain pons-medullary lesions are not of a nature to cause the symptom-complexus of Basedow?—There would then be, in this case, a complexus termed exophthalmic goitre, as well as a complexus termed hemianæsthetic, which, while one of the most frequent of the lighter manifestations of hysteria, in some cases, at least, indicates the existence of a material alteration, localized, as we know, at the level of the posterior third of the internal capsule.

#### The Treatment of Acute Goitre with the Biniodide of Mercury.

Dr. MOUAT, of Bengal, was the first to notice specially the value of the use of biniodide of mercury in combination with the rays of the sun in the cure of goitre. His practice was to use the mercury as an ointment of three drachms to a pound of lard; a portion was rubbed in an hour after sunrise, the patient afterward sitting with his goitre well exposed to the sun as long as he could endure it. After this a fresh layer of ointment was carefully applied, and in ordinary cases a single application was sufficient. Of the value of this treatment in India there can be no question. Surgeon-Major Albert A. Gore reports (*Dublin Journal of Medical Science*) thirty cases which he successfully treated in this way.—*Med. Record*.

#### Treatment of Goitre.

The operation recommended by Mr. SIDNEY JONES (*Med. Press*) consists in excision of the isthmus of the thyroid

instead of extirpation of one or both lobes of the organ; and in a case in which he recently adopted it the proceeding was the most successful possible. A curious consequence of the operation, and on which Mr. Jones laid especial stress, is the invariable atrophy of the gland substances which ensues when the isthmus is taken away.—*Med. and Surg. Reporter*.

#### Galium Aparine as a Remedy for Chronic Ulcers.

Dr. QUINLAN (*British Medical Journal*) has treated cases of chronic ulcer with great success by means of poultices made from "Cleaver's" (*galium aparine*). It has been, he states, used with the most marked success in the following manner: Grasping in the left hand a bundle of ten or twelve stalks, with a scissors held in the right hand, the bundle is cut into pieces about half an inch long. These are thrown into a mortar and pounded into a paste. This paste, which has an acrid taste and slightly acrid smell, is made up into a large poultice, applied to the ulcer, and secured with a bandage. It is renewed three times a day. Its action appears to be a slight, steady stimulant, and powerful promotor of healthy granulation. Its effect in one most unhelpful case was decisive and plain to all. Healthy action ensued, and has since steadily continued; and, after a month of treatment, the two ulcers have been reduced to considerably less than half their original size. A difficulty at once suggests itself as to its general employment, viz., that in winter and spring it is not to be had at all. It appears, however, that this difficulty can be effectually met by the method of ensilage, by means of which green food for cattle has for the last few years been kept perfectly sweet and fresh by bury-

ing it in silos under the ground. This plan is generally known, but all particulars about it can be learned in the pamphlet of Mr. Thomas Christy, F.L.S. (Christy & Co., 155 Fenchurch street, London, E. C.). In the case of the galium, the process would consist of cutting the herb very fine, ramming it down by screw-pressure into a glazed earthenware jar with an air-tight cover, and burying it in the ground. Thus secured from air, moisture and heat, it would be likely to keep through the winter. This plan, if successful, might be extended to other pharmaceutical herbs; for Dr. Quinlan has always had the idea that green herbs are more powerful than dried ones. Indeed, the late Mr. Donovan, of Dublin, used to maintain that, to make tincture of digitalis properly, the alcohol should be brought to where the foxglove was growing, and the live plant plunged into it.—*Med. Record.*

### VENEREAL DISEASES.

#### Double Hydrocele in an Infant.

Clinic of Dr. R. J. LEVIS: This is a case which has been brought here as one of double hydrocele. The baby is three months old. The scrotum is as large as a man's fist and evidently contains fluid. Always endeavor in such a case to discover whether a connection with the abdominal cavity exists, which is readily done by pressing upon the scrotum; if the canal has not closed the fluid will be forced into the peritoneal cavity. I find that this is simply a hydrocele; the inguinal canal is closed.

I am in the habit of simply puncturing the scrotum with a needle and scarifying the wall of the vaginal tunic upon its inner surface; then making mul-

tiple punctures in order to let the fluid gradually drain away. Recollect, you can only adopt this treatment while the sac is still tense, and before you have evacuated its contents. This I repeat on the other side. In an hour or so this entire swelling will be gone, the fluid having escaped in the cellular tissue and become absorbed. It probably will not return; of this, however, I am not absolutely certain.

#### Hydrocele in an Adult Male.

Clinic of Dr. R. J. LEVIS: This case, a man 55 years of age, also exhibits a hydrocele, although limited to the right side, not double, as in the former case. He says that he has noticed a swelling here for two and a half years, which has slowly increased, without pain.

Here is a tumor involving the scrotum of one side, having a pyriform shape, characteristic of hydrocele. There is one point that will often enable you to readily make your diagnosis; it is the appearance of the upper portion of the swelling. In a hernia the upper part of the sac passes gradually into the tissues of the abdomen; in hydrocele, on the contrary, there is a sharp upper termination of the tumor. This is made even more apparent by asking the patient to cough, when an impulse will be communicated through the canal in hernia, but not so in hydrocele. The character of the contents may also be inferred by allowing the light to shine through; or part of the fluid may be drawn off by a hypodermic syringe. Another point is the position of the testicle, which is always at the bottom of the sac in a hernia. In hydrocele it is about two-thirds of the way down at the posterior part of the scrotum.

In using the trocar and canula in tapping, you should bear this fact in mind, so as not to injure the testicle: You

should grasp the trocar with the finger near the end, so as to determine the depth it enters. It requires a sudden thrust and also a rotary motion. As I withdraw the trocar, a clear lymph-like fluid follows. This is a very coagulable fluid, and becomes solid on boiling. It sometimes is so dense that it will not flow at all. The albuminous character of a fluid is well shown, in the absence of the usual tests, by pouring a little in a vessel and allowing water to flow in with some force; if decidedly albuminous there will be a good deal of foam, which will persist.

The tapping is merely palliative, and the fluid will re-accumulate unless measures are taken to prevent it. I usually inject carbolic acid; I formerly used a drachm of a concentrated solution, but as my experience in this practice increases my tendency is to use less. I have frequently used a drachm without bad results; now I rarely use more than half a drachm, and sometimes only a scruple of the crystals, dissolved in a little water. The advantage of this treatment is its painlessness; there is, at the time of first injecting the solution, a not unpleasant sense of warmth, but this soon passes off. Iodine, on the contrary, is very painful. After evacuating the sac with the canula, this solution is thrown in and worked about with the finger, so as to come in contact with all parts of the surface, and the tube is then withdrawn, leaving the solution in the sac.

I usually allow the patient to go about his business for the first day or two, until the inflammation warns him to go to bed. The cure is generally complete in a week or ten days.

#### Stricture of Female Urethra.

Dr. F. N. OTIS reports two cases of stricture of the female urethra treated by

division (*New York Medical Journal*). The first patient had been treated for some time for difficulty in urination without relief. Upon examination Dr. Otis found an urethral stricture admitting a No. 18 French sound. He also discovered a stone in the bladder. There was cystitis. The stricture was divided to 36 mm. with the dilating urethrotome; the finger was then passed and careful search made for the stone without finding it, but a few days afterward a small stone was passed with the urine. In the second case the stricture was the result of gonorrhœa. Cystitis developed and stricture was suspected. Bougies had been passed, but owing to the pain they caused had to be discontinued. Dr. Otis found a stricture of 18 French, as in the first case, which he divided also with the dilating urethrotome up to 36 mm. The cystitis disappeared entirely within a few weeks, but owing to a failure of her physician to keep up the passage of sounds from time to time, recontraction took place within a month down to 26 mm. The patient objecting to another cutting operation, Dr. Otis passed the urethrotome again and turned it up to 36 and drew it out at that size. The pain was not great; the hemorrhage, which was quite free, soon ceased. Great relief in urination followed, but it was feared that contraction would again take place. Dr. Otis remarked that these were the only two cases of well-defined stricture of the female urethra which he had seen.—*Weekly Medical Review*.

#### Stricture of Urethra.

M. GAURON, in some nearly impassable strictures, by means of a funnel, a yard of rubber tubing and an elastic catheter, with hot water, succeeds in getting a sound into the bladder (Can-

ada Practice). The implements being joined together and filled with hot water, the patient lying in bed, and the funnel raised about a yard above the mattress, the oiled catheter is passed as far as the seat of the stricture. The penis is lightly compressed in order to prevent regurgitation of the water, and the sound held in contact with the stricture. Hot water is poured into the funnel, and the column of liquid is maintained to press upon the stricture for three-quarters of an hour. When withdrawing the sound leave the urethra full of water, then immediately endeavor to pass an ordinary sound. In most cases it will pass at once, and may be left.—*Ibid.*

#### DISEASES OF THE EYE AND EAR.

##### The Significance of the Transmission of Sound to the Ear through the Tissues in Aural Disease.

Dr. SAMUEL SEXTON thus concludes his paper on this subject in the *Medical Record*:

1. When the vibrating tuning-fork placed on teeth or vertex is better heard through the tissues on one side, it simply indicates that the better ear excludes wholly or in part such (tissue) transmission, but it does not prove that the auditory nerve in either ear is affected. (Of course, if the nerve of audition be gravely affected, sound will not be heard by any method of conduction.) 2. If the conductive mechanism is absent or greatly damaged in one ear, while the other remains more or less normal, aerial transmission will be found to be ineffectual in the diseased ear, while the tuning-fork allowed to vibrate as before will, therefore, be best heard in the diseased ear, and its vibrations will be almost entirely excluded from the healthy ear. 3. In deafness from

labyrinthine disease, pure and simple, the middle ear being normal, the tuning-fork would be best heard, if heard in any degree, by aerial conduction, because bone conduction would be excluded. (In those extreme cases where destructive disease of the nerve has taken place, impulses of sound may be appreciated irrespective of either the transmitting or labyrinthine structures; thus the deaf-mute is conscious of the sound of thunder, artillery, drums, stamping with the foot upon a floor, and the like.) 4. If the above deductions be true, we may conclude that the tuning-fork is of less value than has been supposed in the differentiation of aural disease.—*Med. & Surg. Reporter.*

#### Remedy for Earache.

In the *Druggists' Circular* a correspondent says: The remedy which I here offer has, after repeated trials, never failed to afford almost instant relief. It is perfectly simple, easy of application, costs but little, and can be procured at any drug store. Here it is, with accompanying directions: Olive oil, 1 ounce; chloroform, 1 drachm. Mix and shake well together; then pour twenty-five or thirty drops into the ear and close it up with a piece of raw cotton to exclude the air and retain the mixture. The remedy I can truly say is a specific in earache. It acts promptly and efficiently, and in my hands has never failed to effect a cure in a short space of time.—*Ibid.*

#### Very Dilute Solutions of Eserine in the Treatment of Weakness of the Ciliary Muscle.

Dr. JOHN C. UTHOFF, Surgeon to the Sussex Eye Hospital (*British Medical Journal*), has met with much suc-

cess in the use of very weak solutions of eserine in cases of failure of accommodation. Two classes of patients, comprising no small proportion of all who resort to ophthalmic surgeons, are specially benefited by instillations of eserine in very dilute solutions. The first and chief class is that of young adults who are slightly hypermetropic, but who enjoy good vision until it is rendered defective by failure of general health, or by overtaking the eyes with excessive near-work. As the power of accommodation fails, the effort to do near-work, especially by artificial light, causes headache, and such work can be performed for short periods only. The use of a weak solution of eserine (gr.  $\frac{1}{10}$  to  $\frac{1}{2}$  j), dropped into the eye three times a day, is attended with great benefit, and may preserve the power of near-vision at its normal standard until, with rest and improvement of the general health, the ciliary muscle regains its normal power. The second class of cases consists of patients suffering from masked myopia, who, even when supplied with proper glasses, are sometimes unable to use them with any comfort for near-vision. The feeble power of accommodation of such myopic eyes may be greatly improved by weak solutions of eserine. In these two classes of cases instillations of a solution of gr.  $\frac{1}{10}$  to  $\frac{1}{2}$  j, used three times a day, were attended in some cases with immediate benefit, the improvement continuing so long as the solution was used, and remaining for a varying period thereafter. In other cases the improvement was maintained only by increasing the strength of the solution. In a few cases—and in but few—no good results were produced by weak solutions. — *New York Medical Journal*.

## DISEASES OF THE SKIN.

### Therapeutic Notes.

The following prescriptions are used by Dr. JOHN V. SHOEMAKER frequently in the treatment of patients at the Philadelphia Hospital for Skin Diseases. For systemic effect :

*Psoriasis*.—℞. Sodii arseniatis (pellels). gr.  $\frac{1}{10}$ . Sig. Dissolve in a little water, and inject into the subcutaneous tissue every day, the dose to be gradually increased until all the eruption disappears.

*Eczema* (Chronic).—℞. Extract. malt.; ol. morrhuae, āā  $\frac{1}{2}$  ij. M. Sig. Two teaspoonfuls three times daily.

*Erysipelas*.—℞. Glycerini; tinct. ferri chloridi, āā  $\frac{1}{2}$  ij. M. Sig. Take from one to two teaspoonfuls in water every three hours until all local irritation subsides.

*Herpes Zoster*.—℞. Morphiae sulph., gr.  $\frac{1}{4}$ ; atrophiae sulph., gr.  $\frac{1}{10}$ . M. Sig. Give as a hypodermic injection every three or four hours until pain is relieved.

*Urticaria* (Chronic).—℞. Acidi sulphurosi; syr. zingiberis, āā  $\frac{1}{2}$  ij. M. Sig. Take from one to two teaspoonfuls in water from three to four times daily.

*Sycosis*.—℞. Ferri iodidi, gr., xl.; aloini, gr. iij.; extracti hyoscyami, gr. ij.; extracti belladonnæ, gr. iij.; ft. pilulæ, No. xx. Sig. One pill three or four times daily.

*Rosacea*.—℞. Fl. ext. ergot; syrup orgeat, āā  $\frac{1}{2}$  ij. M. Sig. Two teaspoonfuls in water three times daily.

*Leucoderma*.—℞. Ferri oleatis, gr. xxx.; quiniæ sulphatis, gr. xv.; acidi arseniosi, gr. j.; extracti ignatiæ, gr. ij. M. Ft. pilulæ No. xxx. Sig. One pill after meals.

*Scrofuladerma*.—℞. Liq. acidi phosphorici co,  $\frac{1}{2}$  j.; ol. morrhuae,  $\frac{1}{2}$  ij. M.

Ft. emulsio. Sig. Two teaspoonfuls after meals.

For local effect :

*Hyperidrosis*.—R. Naphthol, ʒ ij.; tinct. saponin, ʒ ij.; spts. hamamelis virg., ʒ ij. M. Sig. Sponge well several times daily over the surface.

*Seborrhæa Oleosa*.—R. Zinci oleatis, ʒ ij.; pulveris marantæ, ʒ ij. M. Sig. Dust over the surface.

*Pityriasis*.—R. Olei olivæ, ʒ iv.; zinci carbonatis; plumbi carbonatis, āā ʒ ij. M. Sig. Rub well into the parts after an alkaline bath.

*Squamous eczema*.—R. Olei morrhuæ, ʒ iv.; plumbi carbonatis, ʒ ij.; naphthol, gr. viij. M. Sig. Apply after an alkaline bath.

*Scabies*.—R. Olei chlorinati. Prepared by passing chlorine gas in olive oil until it is thoroughly saturated with it. Sig. Mop over the surface two or three times daily.

*Alopecia*.—R. Hydrarg. oleatis fl., ʒ jss.; olei ergotæ, ʒ iss.; olei rosæ, gtt. ij.; olei bergamotæ, gtt. ij. M. Sig. Use as a hair oil.

*Psoriasis*.—R. Ungt. hydrarg. oleatis, ʒ j.; olei cadini, ʒ j.; naphthol, ʒ j. M. Sig. Rub in thoroughly after removing all scales.

*Eczema (Acute)*.—Zinci carbonatis; plumbi carbonatis; lac. sulphuris; pulveris marantæ, āā ʒ i.; ungt. simplicis, ʒ j.; ft. ungt. molle. Sig. Pencil lightly over the surface.

*Seborrhæa Sicca*.—R. Olei ergotæ, ʒ iij. Sig. Apply night and morning.

*Seborrhæa Oleosa*.—R. Naphthol, gr. x.; spts. hamamelis virg. ʒ j.; aquæ rosæf ʒ iij. M. Sponge twice daily over the surface.

*Chloasma*.—R. Ungt. argenti oleatis, ʒ ij. Sig. A small quantity twice daily.

*Acne Indurata*.—R. Naphthol, gr. x.; lac. sulphuris, ʒ ss.; ungt. simplicis, ʒ ss. M. Sig. Use externally.

*Chromophytosis (Tinea Versicolor)*.—R. Ungt. cupri oleatis, ʒ ij. Sig. Rub in a small quantity night and morning.

*Bromidrosis*.—R. Naphthol, ʒ ij.; zinci oleatis, ʒ ij. M. Sig. Dust over the surface frequently.

*Epithelioma*.—R. Ungt. arsenici oleatis, gr. x.; ungt. hydrarg. oleatis, ʒ j.; ungt. simplicis, ʒ j. M. Sig. Spread on old muslin, after which apply to the parts.

*Ulcus (Chronic, with exuberant granulations)*.—R. Ungt. arsenici oleatis, gr. x.; zinci chloridi, gr. v.; pulv. marantæ, ʒ ij.; ungt. simplicis, ʒ ss. M. Sig. Apply by means of old muslin.

*Eczema (Subacute)*.—R. Lac. sulphuris, ʒ ij.; acidi boracici, ʒ ij.; ungt. simplicis, ʒ j. M. Ft. ungt. Sig. Spread over the surface.

*Trichophytosis (Ringworm)*. R. Ungt. cupri. oleatis, ʒ j.; ungt. hydrarg. oleatis, ʒ j. M. Ft. ungt. Sig. Rub in well to the parts.

*Furuncles (Boils)*.—R. Ext. arnicæ, ʒ j.; ext. belladonnæ, gr. x.; ext. opii, gr. v.; ungt. simplicis, ʒ ss. M. Ft. ungt. Sig. Apply constantly to the surface.

*Dermatitis (Erythematous, Vesicular, etc.)*.—R. Lycopodii, bismuth subnit., zinci oleatis, āā ʒ ij. M. Ft. Chartul No. j. Sig. Dust over the surface.

*Scabies (Itch)*.—R. Naphthol, ʒ ij.; lac. sulphuris, ʒ iij.; ung. hydrarg. oleatis, ungt. simplicis, āā ʒ iv.

*Anthrax (Carbuncle)*.—R. Ungt. resinae comp., ʒ j.; ext. arnicæ, ʒ j.; mel, ʒ ij. M. Ft. Ungt. Sig. Use externally.

*Lupus*.—R. Ungt. arsenici oleatis, ʒ ij.; ungt. simplicis, ʒ j. M. Ft. Ungt. Sig. Use constantly on the surface; should pain set in add opium.

*Erythema*.—R. Glyceriti plumbi subacetat., ʒ iij. Sig. Paint or mop over the part.—*Med. Bulletin.*

# **FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.**

## **The Treatment of Fractures in British Hospitals.**

Before speaking of the mode of treating the long bones in detail, it may be well to mention some of the materials which are in use in London at the present time for securing the position of fractures, after the application of splints has been dispensed with, as these means are not uncommonly found available in the first instance, and can be applied in many instances where there is no bruising, and where only one of two bones is broken, as happens particularly in the case of a fracture of the fibula or radius. The principal of these are, the starch or glue bandage, the plaster-of-Paris bandage, and one made stiff with dextrine, gum and chalk, etc. A very useful material for this purpose has long been in use at St. George's Hospital, and can be applied in the first instance in treating fracture of the fibula without bruising, and is almost invariably employed to put up fractures of the thigh or leg as soon as union has taken place and the splints can be laid aside. A piece of ordinary stout millboard is cut to about the size necessary to embrace the limb; it is then soaked in hot water, which renders it pliant, and is shaped roughly to the limb, the edges being torn carefully so as to form a bevelled margin. A piece of flannel is then placed round the limb, or a simple roller is applied, and then a bandage is neatly and firmly carried from the toes to a distance above the joints between which the fracture is situated, and closely embracing the millboard. This, on drying, makes a very convenient apparatus, light and strong, and in order to increase its strength and to keep the bandage from becoming unravelled, a thick coating of

clarified gum is pasted over the bandage. The starched bandage, which is in general use at University College, is applied in much the same manner, coarse pasteboard soaked in starch being used, and the limb being surrounded by an even layer of cotton-wool before this is applied. This being elastic, avoids the danger of compression which might ensue when this treatment is followed, as it often is, in the case of recent fractures; and the apparatus has the advantage, when thus applied, that it can, if necessary, be split up by a strong pair of pliers, and its width curtailed, while its efficacy for support can be re-established by the application of tapes or a fresh bandage. With one of these forms of permanent apparatus it is almost invariably the custom to treat fractures after union has taken place; and in many instances where the displacement is not great and the extravasation slight, recent fractures are also treated in this way. In the case of the bones of the leg, a junk is sometimes slung in a "Salter's swing," and the limb placed in it for a few days, until all swelling and bruising have disappeared. A solution of silicate of potash is sometimes preferred to either of the above-named materials.

To return, then, to the consideration of the fractures of the various bones and the usual plans for their treatment. In London hospitals the general method adopted in case of fracture of the shaft of the humerus is to put the arm up in four well-padded wooden splints, tied together by two pieces of bandage which are made to encircle them, one above and one below, and the forearm, being supported by a sling round the neck, gives sufficient extension to ensure a good position of the broken ends. The fingers and forearm may be left unbandaged, unless there is a tendency for these parts to become swollen, and this

treatment is usually continued until union has taken place, but the plaster-of-Paris bandage can be applied as soon as all swelling has subsided. This form of treatment can be used in all cases of fracture of the shaft, except those of the condyles or of the lower end of the bone, for which a rectangular wooden splint is almost always resorted to, with or without three additional flat splints to encircle the humerus, the one arm of the angle being placed along the front of the forearm, and the other along the anterior aspect of the humerus. Any immovable apparatus is disapproved of in this locality on account of the desirability of making early movement in the elbow-joint, which generally is more or less injured when the accident takes place, and is therefore liable to become stiff if passive motion is not commenced at an early stage.

The old plan of treatment of fracture of the olecranon was to put a long straight splint on the anterior aspect of the arm and thus keep it fully extended, whilst the fragments were brought as nearly as possible into apposition by a figure-of-eight bandage. But when, by the action of the triceps, the upper portion of the ulna was drawn a long way up the arm, this plan was not found to give very good results, which answered, however, sufficiently well when the fibrous covering of the bone held sufficiently together to prevent any great separation of the parts. Accordingly, the plan which has been successfully carried out in the case of the patella has been tried for the ulna, and the parts brought closely together by a silver wire passed through holes drilled obliquely down from the surface of each fragment. Under the antiseptic system this mode of proceeding has been attended with remarkable success in the few cases which have been reported, but it remains to be

seen whether it is capable of being more generally followed.

A couple of well-padded, straight and flat wooden splints are generally all that is required to keep the bones of the forearm in position when fracture takes place in the shaft of one or both, but many plans are in use for correcting the deformity in the injury which goes by the name of "Colles' fracture." Some surgeons use these same splints, and by a turn of the bandage which keeps them in position, passed over the hand, maintain it at an angle downward to the side of the ulna, and obtain satisfactory results. Another very useful apparatus, by which the deformity is more easily corrected, is that invented by Dr. Gordon, of Belfast, who denies that impaction of the broken ends of the radius is of common occurrence, and corrects the deformity "by traction on the hand or pressure on the fragments, placing the hand in the prone position, then applying to the anterior surface of the forearm a splint to which a wooden conical or triangular piece is so attached that the external border of the splint projects beyond it; and on the back of the forearm a straight splint more thickly padded over the wrist than over the forearm," the whole to be fixed by two straps of webbing, and not by bandage. A more convenient and less complicated method in common use is a pistol-shaped splint applied to the back of the hand, with or without a short straight splint to the front of the forearm, and not extending beyond the wrist; the two being kept in position by a bandage.

Passing to the lower limbs, and to the fractures which occur in the femur, the plan of treatment usually followed in London hospitals is by one of the two forms of long splint reaching from the axilla down to the foot, and applied with or without shorter splints surrounding the

thigh. When these are applied, the foot is fixed by bandages to the lower end of the splint, and to an iron foot-piece which runs out at right angles to it, the form of splint known by the name of the French surgeon Desaulx, and this is secured to the body by a band passing round the waist, and runs up on the outer side of the body to the axilla, having a fork cut in the upper extremity for the purpose of giving a secure *point d'appui* for the perineal band, as it is called, by which traction is made. On this band are threaded three short flat splints, the upper ends of which are cut obliquely so as to fit the line of the groin, and these, with the long splint, surround the whole thigh, and are kept in position by one or more pieces of webbing. The whole having been properly adjusted, traction is made by tightening the perineal band, which, by passing over the upper end of the long splint round the groin and behind the nates, causes extension of the whole limb, and brings the fractured surfaces into close and accurate apposition. The shorter splints are, however, very frequently dispensed with, and then extension is effected by means of a weight applied with strapping to the leg and passing over the end of the bed, where an apparatus is fixed with a rest, over which the cord attaching the weight of seven to nine pounds is passed; and to further the effect of extension the lower end of the bed is slightly raised by blocks, so that the weight of the body may act in a manner to extend from the opposite direction. A patient thus treated is usually kept in bed for from four to seven weeks, and then one of the forms of immovable apparatus is generally applied, plaster-of-Paris being less frequently used in the case of the thigh on account of the great weight which a splint made with this material necessarily involves. With very

young children the best results are often obtained by using a weight to the leg as above described, while, to secure the limb from movements during sleep, and to keep the fragments in good position, a sandbag is placed on either side of the thigh, and another laid across the seat of the fracture; and further to prevent the patient from slipping down, and so nullifying the influence of the weight, a band is passed behind the back, from which two loops pass over the shoulders, and this is tied beneath the bed or secured to its upper end. One of these forms of treatment suffices in almost all fractures of the thigh-bone, but there are some in which the broken ends cannot be kept in position by any such means, and this happens particularly when the break occurs a short way below the trochanters, and the upper fragment is drawn upward and inward by the action of the psoas. For these cases the most frequent apparatus used is Earle's bedstead, which allows the patient to lie flat on his back, but the foot being secured on the injured side to a footpiece, the knees are bent over the raised portion of the bed, which thus forms a double inclined plane, and traction is kept up by the weight of the body, the knee thus becoming practically a fixed point. Many other ingenious modes of effecting the same results have been invented and are occasionally used, but they are not in general use, and are only required in exceptional cases; such, for instance, are the methods of placing the limb in a wire support, without splints, and making extension by a weight attached to the foot and passing over a pulley, which is placed at some height and distance from the end of the bed, or the splint known by the name of "Thomas," which consists mainly of a couple of parallel iron rods united at both ends, the upper being secured round the pelvis, and the

lower to a foot, whilst a bandage passes round the whole apparatus and gives support to the lower part of the limb.

The treatment of fracture of the patella varies in detail at almost every institution, but the main points are to reduce the effusion into the synovial membrane of the knee joint, by which the primary separation of the fragments is mainly produced and maintained, and then to bring the two surfaces as nearly as possible in apposition. The first object is attained by raising the limb to an angle with the trunk, on pillows, junks, or other apparatus, and applying evaporating lotions to the joint; and the second, by the use of bandages applied in various fashions, strapping, to which is sometimes attached a weight, which passing over the foot is intended to drag down the upper fragment and to act counter to the retraction of the quadriceps extensor. Some surgeons still use Malgaigne's hooks, but they are objectionable on account of the risk of inducing erysipelas. The operation of wiring together the fragments has already been alluded to, and has now been performed in a considerable number of instances, but the danger, even with the utmost aseptic precautions, is sufficient to deter surgeons from recommending the operation, especially when the accident occurs, as it most frequently does, in persons past the healthiest period of life, and also considering the very useful limb which is obtained by patients who are willing to submit to a prolonged course of treatment by simple means. Where the separation of fragments has taken place after fibrous union between the two ends of bone, the operation has been resorted to in several cases, with more or less satisfactory results. Where splints are used for the treatment of fractures of the bones of the leg, those which bear the name of

Cline are, perhaps, most frequently had recourse to. They consist of two pieces of light pine wood, roughly hollowed out and shaped to embrace the outer and inner surfaces of the calf, ankle and foot, a round hole being cut for the malleolus in each. These are padded with tow or cotton-wool, and are fixed to the foot by pads and bandages, whilst they are secured round the leg by two pieces of board webbing. Other surgeons prefer to support the back of the limb, and for this purpose use three flat deal splints to which a foot-piece is applied, and these are kept in position by webbing and strapping or bandages. Whatever form of splint is used, the custom is almost invariable of swinging or raising the limb, either by junks or by the use of "Salter's swing," which allows the patient to exercise more movement of the body without disturbing the injured extremity. In some cases where the swelling is not great, the limb is placed in plaster-of-Paris, by laying strips of blanket soaked in plaster on either side of the leg, and bandaging with muslin into which the dry plaster has been rubbed, cotton-wool being used, or, as some prefer, a flannel bandage, to guard against the risk of subsequent swelling. For Potts' fracture, where ecchymosis forbids its immediate treatment by some immovable apparatus, the practice recommended by the Dublin surgeon is usually adopted, namely, to place a single flat wooden splint upon the inner side, with a thick pad over the inner malleolus, and to secure to this the foot below and the leg above by light bandage.

The same apparatus suffices in the treatment of compound as in simple fractures, the more so as the wound is almost invariably treated on antiseptic principles, more or less strictly carried out in the manner of Professor Lister.

Some surgeons, however, still adhere to the use of "Assalini's fracture-box," a weighty and somewhat cumbrous machine, whilst others prefer MacIntyre's splint, which has the advantage of being more easily cleaned, and is thus less likely to become a medium of conveying or retaining the germs of contagious diseases.—*Canada Med. Record.*

#### Death Following Extraction of a Tooth.

Two cases of death after extraction of teeth, from infection of the wound, are reported in *Wratsch*. Both were strong, healthy men. The reporter, Dr. SACHAREWITSCH, recommends the careful disinfection of instruments and hands, and the use of antiseptic washes (carbolized water one to two per cent.), after extraction of teeth. After bleeding has stopped, the wound may be packed with iodoform, and sealed with cotton-wadding dipped in collodion. The pain ceased almost at once, and no reaction occurred, in nineteen cases so treated.—*Med. Times.*

#### To Protect Surgical Instruments.

The following is recommended by Prof. OLMSTEAD, of Yale College (*Pop. Sci. News*):

Melt slowly together six or eight parts of lard to one of resin, and stir until it is cool. Rubbed on a bright metallic surface, it protects the polish effectually. It can be wiped off nearly clean, if it is desired, as in case of knife blades, or it can be thinned with coal oil or benzine. The surface should be both bright and dry, as it will not prevent the continuance of oxidation already begun.—*Ibid.*

#### Articular Ganglion of the Knee.

Dr. NICAISE reports, in the *Revue de Chirurgie*, the case of a man who pre-

sented himself for the removal of a small tumor situated upon the outer side of the knee. The tumor was the size of a small nut, somewhat flat, irregularly lobulated, soft, fluctuating at certain points, and irreducible. It was of slow growth, and slightly adherent to the skin and underlying tissues. The joint was in no way involved, and the movements of the knee were perfectly free. A positive diagnosis was not made, though the author was inclined to regard the new growth as a sebaceous cyst. When removed the tumor was found to contain a gelatinous liquid resembling the vitreous humor of the eye. The walls were irregular, presenting here and there little recesses forming a sort of secondary cysts. The inner surface was lined with flat epithelium, outside of which was a cellular shell, interwoven with elastic fibres and presenting in places a fibrous formation, due probably to irritation produced by movements of the tumor.—*Med. Record.*

#### Have we any Therapeutic Means as Proven by Experiment, which Directly Affect the Local Process of Inflammation.

Dr. C. B. NANCREDE concludes a paper in the *Med. News*, on this subject as follows: I think I am warranted in stating the following propositions as the logical and practical outcome of my investigations:

1. During the stage of dilated arteries with increased rapidity of the current, but little danger of capillary changes with exudation need be apprehended, and here, perhaps ergot, certainly arterial sedatives do good either directly or indirectly, without blood-letting, by reducing the size and rapidity of the current, thus allowing the veins of the irritated area time to empty themselves, even of an unaccustomed amount of blood. Thus, if vascular pressure

changes have taken place, the vessels have an opportunity to return to the normal.

2. After stasis has occurred, or while it is occurring, weakening of the heart's action and a diminished volume of the current—*e. g.*, the effect of arterial sedatives—can do nothing but harm to the inflamed area, although, for the reasons given in proposition 1, it may prevent extension of inflammation in the circumjacent parts, which are merely in the earlier stages of congestion.

3. The results to be sought, and which are secured by local blood-letting, are removal of the blood on the venous side, so that the vessels can not only empty themselves, but a certain amount of *vis-d-fronte*—*i. e.*, aspiration, is invoked; this secondarily results not only in a temporary return to the normal on the arterial side, but an increased rapidity and (here is an important point)—lessened force of the circulation. The acceleration of rate without the weakened force of the circulation would further damage the vessels, instead of which the increased rate of the current merely serves to sweep out the accumulated red-blood cells, the cause of the excess of oxygen, and the consequent cell migration. The vehement current also induces a rapid resorption of the effused liquor sanguinis, at once the stimulator to growth, and the food of the cells. This latter advantage is not founded on theory alone, for it is a matter of common observation that the mere amount of blood extracted produces no sensible effects on an inflamed breast, for instance, *at first*, but in a few hours, the skin, if carefully examined, has become wrinkled, and the organ shrunken. This effect is secondary to the loss of blood, and chiefly results from the absorption of the inflammatory exudate.

4. Arterial sedatives in the latter stages are usually inadmissible, except as succedanea to blood-letting, as far as the focus of inflammation is concerned; the surrounding parts, which are merely congested, may be benefited by their exhibition. After blood-letting, they act favorably, because, when the stasis has been overcome, they lessen intra-vascular pressure, and thus permit the blood-vessels to recover their normal condition. They also alleviate pain by lessening the bulk of blood in the part—*i. e.*, they relieve nerve-pressure.—*Med. and Surg. Reporter.*

#### Fish Bones in the Throat.

To remove fish-bones from the throat, Prof. VOLTOLISI, at Breslau, recommends a gargle composed of muriatic acid, 4 parts; nitric acid, 1 part; and water, 240 parts. The teeth have to be protected by lard or oil. The fish-bones become flexible, and they disappear entirely after a short time.—*Weekly Med. Review.*

#### Local Anesthetics.

The following formulæ may be found serviceable as local anesthetics for small operations:  $\mathcal{R}$  Chloral hydrat., gum camphor, aa 3 ij; morphinæ sulph., 3 ss; chloroform, 3 j. M. This may be painted with a camel's hair brush over the area to be incised; allowed to dry and repeated as necessary to render the part insensible. Prof. REDIER proposes the following:  $\mathcal{R}$  Etheris aut chloroform, 3 ij; camphor, 3 i. M. Apply with a brush.  $\mathcal{R}$ . Acidi acetic (cryst.) 1 part; chloroform, 20 parts. Solve. Apply with a brush.—*Med. News.*

#### Habitual Nose-Bleeding and Its Treatment.

Clinically, we may classify attacks of nose-bleeding under three heads: There

are, first, the accidental and incidental attacks, which are common to all; second, there are the frequent and severe attacks which are liable to occur in cases of hæmalophilia, leucæmia, scurvý, morbus maculosus, etc., and in local disturbances where there are polypi, vascular hypertrophies, etc. But, besides these, there are cases, and every practitioner sees them: where the patient suffers for years from attacks of nose-bleed, and where no especial constitutional or local cause seems to be present. A number of German observers have been studying this condition, and recently Dr. O. CHIARI gives in the *Wiener Medicinische Zeitung* a summary of their opinions, with some conclusions of his own. These latter are founded upon considerable personal study and have a practical bearing, so that we venture to present them here. Dr. Chiari believes that in most cases of what he terms "habitual nose-bleed," not dependent on injuries, catarrhs, polypi, etc., the hemorrhage comes from a circumscribed locality in the nose, which can generally be seen and reached. He has studied the history of twelve cases of nose-bleed, nine of the patients male and three female; most of them were young, the age varying between fifteen and twenty years. All had suffered from epistaxis for a series of years. The attacks occurred sometimes daily for a period, in other cases weekly or monthly. They differed in violence; in some cases being slight, in others alarmingly persistent. All the patients suffered from their trouble, there being such symptoms as headache, weakness, anæmia, mental annoyance, etc. The attacks were sometimes brought on by sneezing, blowing the nose, or slight mechanical violence; but oftener they occurred spontaneously, and sometimes even during sleep. In two cases only

did the hemorrhage come from both nostrils.

Now Chiari states that in all his cases the source of the bleeding was a circumscribed spot, generally about the size of a millet-seed, which could be seen on the cartilaginous septum near its junction with the bony septum. By pressure upon this point, bleeding could be stopped. He directed treatment to this point alone, applying generally the galvano-cautery, but sometimes the lunar caustic. Five cases were cured positively; five more did not return to his clinic; two were improved.

The position of the bleeding-point upon the nasal septum was confirmed by Hartmann's observations, and Chiari states that in twenty-two out of twenty-five observations it was found there. The ease with which the hemorrhage is controlled by properly applied compression, and the possibility of curing the trouble, make the observations of Chiari of especial interest.—*Med. Record.*

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#### The Simplest and Safest Method for the Radical Cure of Hemorrhoids.

The *London Med. Record* says that SCARENZIO recommends (*Racconti del Regio Ist. Lomb.*) the elastic ligature in preference to all other and more complicated methods as being the safest and most effectual for the removal and radical cure of hemorrhoids. Its gradual action allows time for the formation of a firm clot in the vein, and the mass separates after two or three days, leaving a simple cicatrized wound. The pain caused is trifling, and only lasts a short time. He has operated often by this method, and has never seen any bad effects follow.—*Med. & Surg. Reporter.*

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#### **The Fruit of *Mucuna Pruriens*.**

Dr. S. MARTIN calls attention to the fruit of *Mucuna pruriens* (D. C.), which, being rich in tannin, may be used in medicine, and might become an article of commerce. It is abundant in South Africa, where its infusion is popularly used as an astringent and sedative for hemorrhoids, and its pulp is applied as a dressing to wounds.—*Bull. Gén. de Thérapeutique*.—*Med. Times*.

#### **The Treatment of Artificial Anus.**

From the *London Medical Record* we learn that Dr. HEINMANN, of Dornhan, gives (*Deutsche Med. Wochensh.*) statistics of eighty-four cases of artificial anus treated by Dupuytren's method, from which one fatal case must be excluded, as having been subsequently treated by resection of the bowel, death resulting in consequence of the binding down and occlusion of the canal by a false ligament. Of the remaining eighty-three cases seven died, giving a mortality of about one in twelve, or 8.5 per cent. But of these seven cases, three, noted by Dupuytren, died in consequence of "indigestion;" one patient, seventy-eight years of age, operated on by Hamburton, died from marasmus, after a successful operation; and the cause of death in a case of Velpeau's was the employment of the scissors too soon (twenty days) after the formation of the artificial anus. This leaves only four deaths to be attributed to the operation itself, giving a proportion of one to two on the total mortality. In seventy-six of the eighty-three cases the result was more or less favorable. In fifty (60.2 per cent.) the artificial anus completely healed up; in twenty-six (31.3 per cent.) a small fistula was left, which could, however, be so well closed by a compress that the patients could resume

their operations, which were in some cases very arduous. The author recommends Dupuytren's clamp as a means by which patients can be cured, or at least relieved, without danger to life; but he points out the necessity of making a thorough examination and demonstrating the existence of a spur (Sporn) before having recourse to it, and of screwing it up gradually, so that only a small portion of the spur may be included each time, and, finally, the danger of employing it too soon after the establishment of the artificial anus. Perforation, which has been cited as a likely cause of death, occurred only in two cases, in operations by Dupuytren and Gherini; and peritonitis, extending from the portion of peritoneum included in the clamp, mentioned by Dieffenbach as a possible fatality, was the cause of death in only one of the eighty-three cases. The only remaining objection to the operation is its slowness, the time required for cure being from three to six months; but this ought not to come into consideration in comparison with a decidedly more dangerous procedure.—*Med. and Surg. Reporter*.

#### **Imperforate Anus.**

Dr. B. W. HINDS reports this case in the *Southern Practitioner*:

The child had been born fifty-six hours, and, in consequence of the long time which had elapsed, was in great pain. I made a careful examination, exploring the parts carefully, satisfying myself that I could discover vestiges of an opening through the expanded sphincter, circular in form, and about the proper distance between the scrotum and coccyx for the anus. I proceeded at once to operate, and selecting from my pocket-case such instruments as I thought necessary, placing the child in the lithotomy position, an assistant hold-

ing it firmly, I made an incision five-eighths of an inch long, with an ordinary bistoury, along the raphéal line. I then took a probe-pointed bistoury, with which I made a cross incision of about the same length as the one first made, completing the operation. To my great satisfaction the meconium passed immediately, giving me full assurance of the fact that my operation was thus far successful. After the bowels had acted sufficiently I applied a pledget of lint with compress and bandage, and retired for the night, giving instructions to the nurse to watch for hemorrhage; but she got careless during the night, let the bandage get off, the compress fell away, and hemorrhage took place to an alarming extent; which, when I awoke, I stopped immediately by the application of a new bandage and compress, saturated with alum. There being only a tegumentary covering, reducing the malformation to the simplest variety, the treatment was necessarily simple. Every day for three consecutive days I opened the orifice with a large silver catheter, following it in a short while with a slippery-elm bougie made from the bark fresh cut from the tree, letting it remain *in situ* for twenty or thirty minutes each time. This constituted the entire treatment. The child recovered with a perfect anus, the sphincters contracting naturally. There is nothing peculiar about this case of which I am aware, except that the raphéal line extended all the way from the scrotum to the os coccyx. There was one artery, a branch of the perineal, running longitudinally with the raphé, that I think was inordinately large.—*Ibid.*

#### The Healing of Wounds of the Spleen.

Dr. DANNENBERG (*St. Petersburger Inaug. Dissertation*) wounded, in various ways, the spleen in fourteen dogs, killed

the animals in periods varying from twenty-four hours to one hundred and eight days, and examined numerous specimens microscopically. He sums up the results of his investigations as follows: 1. Incisions into the spleen are prone to rapid union; some amount of gaping occurs only on the surface of the organ. 2. Incisions into the pulp are prone to heal without suppuration. 3. Suppuration of the splenic tissue, in the course of a wound, occurs only as a rare exception. 4. Adhesion of the splenic capsule to the omentum, which develops very rapidly, is one of the conditions leading to healing of wounds of the spleen. 5. Perforating wounds heal slowly, and always through development of granulation-tissue. 6. Punctured wounds heal by the first intention. 7. Amputation wounds of the spleen heal by its adhesion to the omentum, resulting from the formation of connective-tissue between the parts. 8. In the formation of a scar, both the proliferating elements of the splenic pulp and the epithelioid elements of the reticulum take part. 9. Hypertrophy of the subserous layer of the capsule depends on the proliferation of cells of connective-tissue. 10. There is proceeding an extremely active proliferation of capsular epithelioid tissue around the edges of a wound. 11. There is proceeding a complete regeneration of the epithelioid covering on the surface of a cicatrix left by a wound. 12. Under certain conditions common epithelioid cells may undergo transformation into cylindrical and cuboid epithelioid elements.—*Med. Record.*

#### Permanganate of Potash vs. Carbolic Acid.

Dr. C. ROBERTS believes that a solution of the permanganate forms the most delicate test of the asepticity of sponges, as it leaves a brown mark on any collec-

tion of organic matter, so that in the *Brit. Med. Jour.* he recommends this as a test of their purity, after washing in carbolic acid.—*Med. and Surg. Reporter.*

#### Naphthaline as an Antiseptic.

In a monograph entitled *Die Wundbehandlung mit Naphtalin*, Dr. CARL BONNING has formulated the results of upward of fifty cases in which naphthaline dressings were employed after operations in the Strasbourg surgical clinic. From a study of these cases, as also of a number of other less serious injuries treated in the polyclinic, he feels justified in regarding this substance as a most valuable antiseptic. He sums up its advantages as follows: 1. It is very cheap—a consideration not to be despised, especially in hospital practice. 2. It is convenient to handle and easy of application: it is simply sprinkled in powder upon the wounded surfaces and the dressings, or cavities may be filled with it. 3. It is not poisonous, and thus may be used without fear in cases in which the employment of carbolic acid or iodoform might be attended with untoward consequences.

In a brochure on the same subject (*Naphtalin in der Heilkunde und in der Landwirthschaft*), Dr. ERNST FISCHER speaks most highly of its destructive action upon the lower forms of animal and vegetable life. He advances the same considerations in its favor as does Dr. Bonning, viz.: its ease of application, its non-poisonous properties, and its cheapness. Among its disadvantages he recites: 1. Its insolubility in water, whereby it is unsuitable for the disinfection of wounds which are to be closed by suture. 2. Its disagreeable odor. 3. The profuse secretion which naphthaline excites where it is applied to a large extent of wounded surface. He recom-

mends its use also in skin diseases of parasitic origin. The second part of the monograph is devoted to a consideration of the value of naphthaline in agriculture, and especially of its destructive action upon the phylloxera.—*Ibid.*

#### Dressings for Wounds.

The list of materials which have been suggested for the purpose of dressing wounds is already so considerable that it would almost require a lifetime to test them by practical experience and to estimate the rival claims of the various dressings. (*Medical Times and Gazette.*) Imbued as we were with the notions of antisepticism circulated by Professor Lister, the restoration to use of such apparently unclean substances as turf, moss and mud came upon us as a startling event when we had been trained to look upon all unprepared articles as scientifically filthy and improper. From Professor Bruns, of Tübingen, we receive a fresh addition to our means for carrying out the after-treatment of wounds, in the form of a preparation which he calls "wood-wool," and which he recommends to surgeons. (*Berl. Klin. Woch.*, No. 20.) Fine-grained wood in the form of splinters and shavings, such as are largely employed in paper factories, according to Bruns, is the kind of material to be used in preparing the dressing which is called wood-wool. Pine wood is preferred, and especially the *pinus picea*, which is poorer in resin and of coarser grain as compared with the wood of other pines and firs. The further preparation of the wood shavings and splinters consists in their reduction to a state of finer division by being rubbed through a wire sieve, then dried, and finally impregnated with various antiseptic substances. That considered best is a half per cent. of corrosive subli-

mate and ten per cent. of glycerine (the percentage apparently referring to the ratio between these substances and the wood-wool). The advantages of such a dressing are believed to be manifold. Compared with ashes and turf it is absolutely clean, fresh, and of white color, and is soft and pliable like ordinary wool, and withal of extraordinary cheapness. It possesses, in virtue of its contained resin, ethereal oils, certain antiseptic properties, and it is so easily adapted to the wounded parts and has such elasticity that a uniform and equal pressure is easily obtained. Its principal property, however, is its extraordinary power of taking up fluids; in this it excels all other forms of dressings; it absorbs twelve times its own weight of fluid, so that ten grams of dried "wood-wool," after complete saturation, weigh one hundred and thirty grams. Simple sawdust absorbs only three or four times and a half its weight of water, ashes only nine-tenths and sand only four-tenths. This dressing has been in use by Bruns for half a year, and he has every reason to be greatly satisfied therewith. With the exception of one case of erysipelas, no secondary accidental wound diseases were met with.—*Ibid.*

#### Charbon.

The following are the main symptoms of milzbrand (malignant pustule charbon, Anthrax malignus) as given by the government at Opelin, Germany (*Deutsche Med. Zeitung*), as several cases have recently occurred in that neighborhood. Malignant pustule is a specific infectious disease which occurs chiefly in herbivora, and can be transmitted from these to various other animals and man. The poison is due to the presence of bacteria in the blood of the animals, deposited most profusely in the spleen, as well as

in the mucous membrane of the intestine and the lymphatic glands. In consequence of the immensely rapid multiplication of these spores, not only the interior and exterior of the animal is filled with them, but also the ground, the food, the drink, and the stalls of the animals. From experience we know that malignant pustule arises most readily in damp river valleys and on warm, humid ground, rich with humus and underbedded with clay, which prevents drainage. Pasturing animals on swampy meadows, and watering them from stagnant pools, as well as feeding them on plants that grow in the localities where the cadavers of animals dead with malignant pustule lie buried, will favor the production of the disease. The disposition to malignant pustule is different with various animals. Sheep, goats and cats are most readily taken, then horses, swine and dogs, while cattle have comparatively the least disposition to be infected. The symptoms are peculiar. In herbivora the malignant pustule is generally manifested suddenly. Animals that a few minutes before were quietly feeding, retreat from the trough, extend their head and neck, and die in a short time. Rarely do they live several days; then swellings appear in various parts of the body, which sometimes acquire large dimensions. At first hot and painful, they become cold in twelve to twenty-four hours. Often gases are developed in them, so that when the hand is passed over the tumors crepitation is produced, and from one or more openings sanguinolent pus exudes. This as well as any manipulation with the quickly decomposing cadaver will very readily infect the human subject. Malignant pustule does not occur idiopathically in man, the only means of infection being direct transmission of the poison from animals. In most cases infection results

from occupation with animals sick with malignant pustule, or in slaughtering these animals, and especially in flaying and eviscerating them. As the poison is uncommonly tenacious, is not destroyed by considerable cold, and persists in its virulence, even after years, it may be readily transmitted from the offal of the cadavers to dealers in hides, tanners, harness makers, and wool combers. Even from stockings made of the wool of the diseased sheep infection may occur. Not infrequently flies have been proven to be the carriers of the poison. The consumption of meat of animals who suffered from malignant pustule is highly dangerous to man. It is, therefore, necessary to use the greatest care in handling such diseased animals or their cadavers; also, in removing the cadaver or its excreta and disinfecting the ground and surroundings of the diseased animal. The best method to dispose of the cadaver is to burn it or to boil it until the soft parts have entirely fallen to pieces. The interment of the body is not sufficient security against the propagation of the poison.—*Weekly Med. Review.*

#### DISEASES OF THE EYE AND EAR.

##### A Case of Amaurosis Treated by the Percuteur.

There is a little instrument called the percuteur, recently invented by Dr. MORTIMER GRANVILLE, by means of which a number of taps in regular and very rapid succession, and of varying intensity, can be given to any part of the surface of the body. Dr. Granville's theory of pain is that it is due to abnormal vibrations in a sensory nerve, and he explains the action of the percuteur in the cure of pain and other symptoms by the theory that it induces a

new and orderly set of vibrations in the nerves to which it is applied. Dr. W. Carter relates a case in the *Liverpool Medico-Chirurgical Journal*, in which the application of this instrument was followed by the most striking benefit. He is not prepared to accept Dr. Granville's theory of the action of the percuteur, nor is he inclined to assert positively that his case was cured by it, but leaves his readers to form their own conclusions. The patient was a man forty-five years of age, of excellent physique, free from any taint of syphilis or hereditary disease. About five weeks previously he was seized, without any premonitory symptoms, with a headache located chiefly in the temples. The following day the pain was worse, and was accompanied by a little chilliness and general malaise. Several times during this day he observed a dimness in the right eye. On the next day he was forced to go to bed, by the severity of the pain in the head. On the fourth day he was totally blind, and experienced great pain in the eyeballs when moving them from side to side, but not when he moved them up and down. By the end of the week all pain in the head and eyes had disappeared, but the amaurosis persisted. Several careful ophthalmoscopic examinations revealed no abnormality. The pupils were dilated and but slightly responsive to light. Leeches were applied behind the ear, and iodide of potassium and solution of the perchloride of mercury were administered internally. His condition remaining unchanged, Dr. Carter directed that the percuteur be applied daily for five minutes to the eyeballs and temples respectively. At the end of the week the patient was able to pick his way through the ward without assistance, and at the expiration of a month was able to read coarse print and to

walk briskly through a crowded street without a guide. He was again submitted to an ophthalmoscopic examination, when it was discovered that he had commencing cataract in each eye. The author, while feeling no more certain that this lesion was a result of the treatment than that the restoration of sight was attributable to the same agency, is yet inclined to think that the rapidly successive taps on the globe of the eye so modified the structure of the lens as to lead to the production of cataract.—*Med. Record.*

#### Insufflation of Iodoform in Chronic Otorrhœa.

Dr. COERALY PEREZ states that he uses insufflation of iodoform in all cases of otorrhœa, especially those in sequence of scarlatina and roseola. He cleanses the ear first with injection of phenic water, dries it carefully and insufflates finely pulverized iodoform quite liberally for three or four days. Then he washes it again with alcoholic water, dries it, and returns to the insufflation of iodoform until the flow is arrested.—*Revista Medica de Sevilla.*

### VENEREAL DISEASES.

#### Diagnosis of the Different Forms of Urethral Discharge.

Dr. FÜBINGER thus distinguishes the different discharges taking place from the male urethra (*Centralb. für klin. Medicin*): Spermatorrhœa is a loss of seminal fluid which occurs during defecation or at the completion of micturition. The condition, which is much more common than is ordinarily supposed, is not a final stage of pollutions, but is caused most frequently by gonorrhœa and sexual abuses. Spermatorrhœa becomes azoöspermatorrhœa

when for any cause (usually from epididymitis) the testicles cease to produce spermatozoa. Prostatorrhœa is the discharge, sometimes continuous, sometimes during defecation and urination, of the prostatic secretion. It is a rare condition, and is a symptom of chronic prostatitis, usually of gonorrhœal origin. Urethrorrhœa ex libidine is a phenomenon occurring usually in anæmic and nervous individuals. It consists of a scanty discharge, without orgasm or ejaculation, accompanied by intense sexual excitement and strong erection. The last discharge to be considered is gleet.

Of these five processes two are easily recognized. Spermatorrhœa is evidenced by the presence in large numbers of spermatozoa (a few here and there signify nothing), and urethrorrhœa is readily recognized by its characteristic mode of onset. The secretion of the latter is the product of the urethral glands, and Cowper's glands. It is clear, stringy, and contains but few epithelial and round cells. A very abundant discharge points to azoöspermatorrhœa. The absence of pus-corpuscles also points to the same condition, though their presence has no weight on the other side, as urethritis may exist at the same time. In such cases the presence of specific secretion of the seminal vesicles must be determined. If one finds a jelly-like substance resembling in shape grains of sago, that is conclusive; but if this is not found, it may be that it is in solution, and may then be precipitated by a strong alkali. The secretion is allowed to stand for a time, and then a clear drop is placed in a watch-glass, and a drop of caustic potash added. If now the drop shows a thick white cloud, or streaks, it is evidence that the secretion contains seminal fluid. If this process

shows that we have not to do with azoösperratorrhæa, there still remains the differential diagnosis between prostaticorrhæa and gleet to be determined. In the latter the discharge is very scanty; in the former, digital examination reveals great tenderness on pressure of the prostate gland. Indications of prostaticorrhæa are: 1, the presence, unfortunately not constant, of numerous amyloid bodies; 2, numerous typical cylinder cells, especially when in the double layer arrangement of glandular epithelium; 3, the large Böttcher's crystals. The presence of the latter is ascertained by mixing a drop of the secretion with a drop of a 1 per cent. solution of phosphorated ammonia upon an object glass. In about an hour numerous large, exceedingly beautiful crystals are found. The secretion of the prostate, the author insists, is not clear, odorless and thick, as usually stated, but is thin, of a milky cloudiness, and possesses the characteristic odor of spermatic fluid.

An aid to diagnosis is also found in the time of the appearance of the secretion in the urine. The first and last portions are to be separated from the principal flow of the urine. The presence of the secretion in the first portion points to gleet; in the first and second portions to prostaticorrhæa; in the third portion to azoösperratorrhæa. The latter appears in the form of nearly transparent, thick, stringy masses, and sometimes also in the shape of sago grains.—*Med. Record.*

#### Electrolysis in Strictures of Urethra.

Dr. ROBERT NEWMAN, of New York, gives the following directions for the management of the battery, etc. (*N. E. Med. Mo.*):

1. The *battery* needed is any good, steady *galvanic* battery; the 20-cell

Drescher battery is a good and cheap instrument, sufficient to begin with.

2. The *fluid* for the battery ought not to be too strong.

3. *Rheostat* and *galvanometer* attached to the batteries are convenient niceties, but for our purpose and the battery used, *not* necessary.

4. For the positive pole a carbon electrode is used, covered with sponge, moistened with warm water, and held against the cutaneous surface of the patient's hand, thigh or abdomen.

5. For the absorption of the stricture the negative pole is always used.

6. Electrode bougies are firm sounds insulated, with a bard-baked mass of rubber; the point is a metal bulb, egg-shaped, which is the acting part in contact with the stricture. These electrode bougies are made by instrument makers.

7. The curve of the bougies is short; large curves are mistakes.

8. The plates must be immersed in the battery fluid before the electrodes are placed on the patient, and raised again after the electrodes have been removed.

9. All operations must begin and end while the battery is at zero, increasing and decreasing the power of the current slowly and gradually; avoiding any shock to the patient, or any interruption of the current.

10. Before operating, the susceptibility of the patient to the electric current should be ascertained.

11. The problem is, to absorb the stricture, not to cauterize.

12. At first it is best to operate only by the first method of absorption, "*weak currents, at long intervals.*"

13. The exact number of cells to be used cannot be given; it must be regulated according to the work to be done. As a general rule, six to twelve cells may be used.

14. The seances should be at intervals, not too frequent in succession.

15. The best position for the patient to assume during the operation is that which is most comfortable for him and the operator. I prefer the erect posture, but the recumbent or others may be used.

16. Anesthetics I like to avoid; I want the patient conscious, so that he can tell how he feels.

17. Force should never be used; the bougie must be guided in the most gentle way; the electricity alone must be allowed to do the work.

18. During one seance, two electrodes in succession should never be used.

19. All strictures are amenable to the treatment by electrolysis.

20. Pain should never be inflicted by the use of electrolysis; therefore, it should not be applied when the urethra is in an acute or even subacute inflammatory condition.

## DISEASES OF THE SKIN.

### Human Parasites.

Dr. GEORGE SUTTON gives the following list, showing the principal parasites which infect the human system:

*Microzymes*.—Micrococci: Probably of smallpox, cow-pox, measles, scarlatina, varicella, erysipelas, syphilis, gonorrhea. Bacilli: Probably of typhus fever, typhoid fever, tuberculosis, anthrax, leprosy. Vibriones. Filaria: Probably of elephantiasis. Spirillum: Probably of relapsing fever. Bacteria: Probably of septicemia.

*Entozoa*.—Vermes—Cestoda: Probably of tenia elliptica, tenia flavo punctato, tenia mediocanellata, tenia latus, tenia solium, tenia bothriocephalus caudatus; tenia bothriocephalus latus. Nematoda: Probably of ascaris lumbrici-

coides, ascaris mystax, oxyuris vermicularis, filaria medinensis, dochmius duodenalis, trichocephalus dispar, trichina spiralis. Trematoda: Probably of monistoma, distoma.

*Epizoa*.—Insects—Acarus scabei.—Pediculida: Probably of pediculus capitis, pediculus vestimenti, pediculus tabescentium, pediculus pubis originalis. Pulex: Probably of pulex irritans, pulex penetrans. Ixodia: Probably of ixodes Americanæ, ixodes numarius, ixodes crenatus.

*Undoubted vegetable parasites and their diseases*.—Microphites—Achorion schönleinii: Probably of favus. Trichophyton tonsurans: Probably of porrigo scutulata. Microsporon audouini: Probably of porrigo decalvans. Microsporon mentagrophytes: Probably of mentagra. Microsporon furfur: Probably of tinea chloasma.—*Cincinnati Lancet and Clinic*.

### Moist Hands.

Mr. H. A. SMITH writes in the *British Medical Journal*: Moisture of the hands (local hyperidrosis) is a purely functional disorder of the skin, due to disturbances of the nervous system. Stout women, generally servant girls, suffer from it, although the fair votaries of the ball-room and members of good society, together with those of lithe and nervous habit, occasionally come under notice. It may or may not be attended with pain and inflammation, dysidrosis or fetorodidrosis, or, more rarely, pigment-chromidrosis. As a rule, the axilla and feet sympathize more or less. As the condition appears to be due partly to abnormal vascular conditions, but mostly to irritability or undue stimulation of the vaso-motor nerves, probably of central origin, the following lotion will be found exceedingly useful: R. liq. plumbi subacetatis, 3 iij. Sp.

vini methylati,  $\frac{3}{4}$  j. Aqua rosæ, ad  $\frac{5}{8}$  x. Fiat lotio. The lotion to dry on, and the hands subsequently to be dusted three times daily with powder composed of equal parts of calamine and starch powders. The patient should wash the hands always in cold water, and well dry them, and should avoid malt and all fermented liquors, pickles, spices, tea and coffee (taking cocoa), and be sparing in the use of sugar. The lotion failing, she should wash the hands thrice daily with carbolic acid soap in soft water, in which half a dram of extract of belladonna has been previously dissolved, and take a pill containing valerianate of zinc, two grains; quinine,  $1\frac{1}{2}$  grain; and extract of belladonna, one-fourth grain, with conf. rose q. s. t. d. s. A mixture (if any tingling or burning in the fingers) containing bromide of potassium, digitalis, and a vegetable tonic, will complete the treatment. The belladonna, besides causing vaso-motor paralysis, contracts the unstripped muscular fibres surrounding the arterioles going to supply the sweat gland, and carbolic acid has a benumbing effect on the nervous filaments supplying these and the papillæ of the skin proper.—*Med. Record.*

#### The Absorption of Watery Solutions by the Skin.

From an examination of this subject (*Ann. de Dermatol. et de Syph.*) Dr. AUBERT concludes the following: 1. Substances dissolved in water may make their way through the epidermis without producing any visible external lesion. 2. Nevertheless, the essential condition of such penetration appears to be a break in the epidermis where it is prolonged into hair-sheaths, and along the included portions of the hairs themselves. 3. In fact, according to our ob-

servations, this penetration takes place exclusively in hairy parts. 4. It is promoted by whatever causes the hair to be pulled about, as, for instance, friction with the moist or dry hand, or unusual size, stiffness, and length of the hairs. 5. A delicate integument and thin cuticle afford unfavorable conditions, on account of the less vigorous growth of hair on parts thus endued. Total absence of hair is likewise a condition eminently unfavorable to absorption. 6. Hence we may infer the possibility of introducing soluble substances into the circulation by causing them to penetrate the epidermis in small quantities, either with or without the aid of baths. To effect this, friction with the palm of the hand would have to be applied forcibly over a large surface, and especially where the skin is hairy. The only possible unpleasant effect would be a moderate degree of inflammation manifested in a little redness and smarting about the roots of the hair. 7. Simple immersion in a bath, however prolonged, could not be relied on to effect the entrance of even the smallest quantity of a solution through the skin.—*Med. Record.*

#### Pomade for Eczema of the Face.

M. GALEZOWSKI (*Progrès Médical*) recommends the following preparation for those cases of eczematous or impetiginous eruptions which, in children, often accompany phlyctenular keratitis: R. Oil of cade, camphor, aa, 25 centigrammes; red precipitate, 10 centigrammes; vaseline, 10 grammes. M. When numerous crusts are formed it is well to remove them with a suitable forceps, and to cauterize the surfaces thus uncovered with a light application of nitrate of silver, the excess of which is to be neutralized with a solution of salt.—*New York Med. Journal.*

## FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.

### Treatment of Fractures of Patella.

PROF. J. S. WIGHT (Proceedings of Kings County Medical Society):

I have here a quadrangular piece of pine board, fastened together at a right angle with pieces of wood glued in at the angle so as to make it firm and resistant. On this end here, are two bars; they are put on with hinges on their sides. These bars are movable. On these two bars is a piece of canvas or cotton cloth, which is sewn on these bars. The bars are movable, and go up and down, for purposes which you will see presently. There are two wheels, and pulleys with grooves. Here is a hook for the purpose of hanging a loop of ordinary bandages, which are attached to the bars. I take this roller bandage and fasten it on the cross-bars. Then you can raise the bars and leave them raised, or lower them with perfect ease. Place it at that angle there and it makes a single inclined plane. Whether there is an injured limb or a fractured patella, it may be used with equal facility. The limb rests easily on it. If necessary you can make a hole for the heel, and if necessary pad it with a little oakum. We have here a quadrangular piece of adhesive plaster of the best kind. It will stick; it will hold its place, I believe, and stick in all kinds of weather—hot, cold, moist or dry. I have cut it, as you see, in the form of a bootjack. I take a scissors and cut little slits in this plaster; then stick it on the limb. This notching of the plaster, you will find, is an excellent idea in the use of all plasters. It makes the plaster stick with greater ease, facility and tension. Then I take this quadrangular piece of adhesive plaster and lay it on the ante-

rior surface of the thigh, on either side, and against the upper edge of the patella. I feel that it is exactly against the upper surface of the end of the patella. Then I take a roller bandage, and begin here at this point and roll it around the limb firmly against the upper portion of the fragment. By the application of the bandages in that way, I get hold of all that is possible of the quadriceps extensor of the leg or thigh. You do not get hold of it completely; but you have all you can get of the skin all around, and that holds some of the fascia, and in that way you can pull down the upper fragment—especially as you have hold of the fragment here. And this is what the pulley is for. Here is attached to the adhesive plaster, small cords, to which are attached small sash weights, weighing about  $3\frac{1}{4}$  lbs. Now I will pull upon the the quadriceps extensor with a force of  $3\frac{1}{4}$  lbs. If any one thinks there is no force here, let him carry one of these weights upright at arm's length for a length of time, and he will change his opinion. On the other side of the limb we have the same thing, so that we have here a force of  $7\frac{1}{2}$  lbs. upon this limb. There is only one thing more. The lower fragment will tilt up; but this may be prevented by putting upon it a sand-bag, and it will keep it down. If the sand-bag falls off, put it on again and keep it on. That presses the fragments together; and, more than that, the patient is always comfortable. If he slips up in bed these weights go up, and if he slips down these weights go down with him; and he is always comfortable in any position he can put himself in.

### The Radical Operation for Hernia.

From a careful study of upward of four hundred cases, Dr. LEISINK ar-

rives at the following conclusions: 1. The radical operation should never be attempted for the cure of reducible hernia. 2. In the case of very large and painful, or of otherwise incapacitating hernias, the operation is justifiable. 3. Old and feeble persons and very young children should not be exposed to the risks of this operation. 4. The radical operation is indicated after the reduction of strangulated hernia, unless for any reason it be desired to keep the canal open. 5. A radical cure is very seldom obtained; yet (6) the condition of the patient is usually greatly bettered by the operation. 7. In every case a truss should be worn after the operation. 8. The radical operation should always be performed under the most strict antiseptic precautions.—*Deutsche Medicin. Zeitung.*

#### **Surgical Treatment of Dupuytren's Contraction.**

In a brochure on Dupuytren's contraction of the palmar fascia and its treatment, Dr. CHEVROT describes a method pursued by Busch in the correction of this deformity. A triangular tongue of skin is dissected up from the palm, the base of the triangle resting in the crease which separates the contracted finger from the hollow of the hand, and the apex terminating at the point of greatest prominence when the finger is forcibly extended. The base of the triangle is left attached while the rest of the flap is dissected up, as much of the connective tissue as possible being raised with the skin. All the contracted bands of the aponeurosis are divided, until complete extension of the finger is obtained. The flap of skin retracts, leaving a triangular space in the palm uncovered. The edges are approximated as far as possible, and a compress applied. A retentive splint should be

applied and maintained until the cure is completed. If this method is pursued the danger of wounding the sheaths of the tendons is reduced to a minimum.—*Bull. Gén. de Thérapeutique.*

#### **How to Remove a Tight Ring.**

A novel method of effecting the removal of a ring which has become constricted around a swollen finger, or in any other similar situation, consists simply in enveloping the afflicted member, after the manner of a circular bandage, in a length of flat India-rubber braid, such as ladies make use of to keep their hats on the top of their heads. This should be accurately applied—beginning, *not* close to the ring, but at the tip of the finger, and leaving no intervals between the successive turns, so as to exert its elastic force gradually upon the tissues underneath. When the binding is completed, the hand should be held aloft in a vertical position, and in a few minutes the swelling will be perceptibly diminished. The braid is then taken off and immediately re-applied in the same manner, when, after another five minutes, the finger, if again rapidly uncovered, will be small enough for the ring to be removed with ease.—LANGON.—*Gaz. des Hôp.*—*Proceedings of the Med. Society of the County of Kings.*

#### **Treatment of Club Foot.**

Dr. CHARLES F. STILLMAN (*N. Y. Med. Jour.*): There has been a want in surgery for a light and effective apparatus for weak ankles when associated with inverted feet for the less severe forms of talipes varus, especially when due to infantile paralysis, and for the after-treatment of such cases as have been subjected to operation. There are three tendencies in the deformity which

should be combatted by such an instrument in order to render it effective as a curative agent.

These are (1) adduction or local inversion at the ankle; (2) supination, or turning under of the foot, the ankle giving way externally; and (3) contraction of the posterior muscles by which the os calcis is drawn upward, thus forcing the astragalus forward and causing prominence of the metatarsal bones on the dorsum of the foot.

When a case presenting these symptoms comes to the surgeon, it is generally passed over to the instrument-



FIG. 1.

maker who supplies a simple heavy retentive brace (see Fig. 1), with a strip passing up each side, which makes no provision for the first and third symptoms at all, and only partially succeeds in overcoming the second, while its unnecessary weight is detrimental (due to the presence of the extra strip on the inside of the ankle), in paralytic cases especially; or perhaps, the patient may be provided with a "Hudson" brace (Fig. 2), recommended by Dr. Sayre, which fulfills the second and third indications, partially, and the first not at all, and possesses the same demerit of weight.

It would seem, with an elastic strap

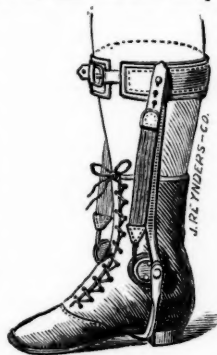


FIG. 2.

on each side, that the third indication would be fully met by this brace, but this is to some extent defeated by there being no provision whatever for the production of local eversion of the foot, it being rigidly secured in the median line between the two side-strips. Where any foot is outwardly rotated as far as possible, it is thereby placed in the position in which the origin and insertion of the peronei muscles are most nearly approximated, and in this position the elastic force operates to best advantage in lifting the heel, because if the foot is held at its extreme outward angle with the leg (extreme eversion), and is seized under the ball and pushed upward, the metatarsal bones and astragalus will be replaced in position, leaving no prominence on the dorsum whatever, and the os calcis will be pushed back by the astragalus, thus causing a direct reversal of the process of the deformity—a result which cannot be attained if the foot be held in the median line, as by the "Hudson" brace. There should be provision in the brace for outward lateral movement or eversion, as this is necessary for correct physiological treatment. To avoid weight, I use one side-strip instead of two, and that is placed externally, is articulated opposite the ankle, is riveted to the shoe beneath the arch, or to a metal insole if concealment be desired, and attached by two girths to the leg, one just below the knee and the other above the ankle, so that the muscular portion of the leg is not constricted or encumbered (see Fig. 4).

When a side-strip is worn on the inner side of the leg, it is apt to interfere with locomotion, leading to frequent falls, a result to be avoided by having it placed externally only—as in those being described. In order to fulfil the three indications already given, the sin-

gle side-strip just described is to be fitted with two ratchets and an elastic strap. These ratchets are clamps, as shown in Fig. 3, and were described by

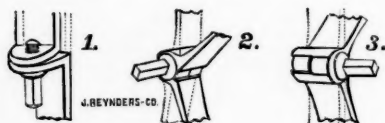


FIG. 3.

me in the New York *Medical Record*, as admitting either fixation at any angle or free motion. In this case we use them for fixation in preference to any other ratchet, both for symmetry and for ease of fabrication, the latter being an important item in the expense attending a brace.

One ratchet is to be placed just below the ankle for rotation (see Fig. 4),



FIG. 4.

and allows that part of the brace below it to be thrown out and fixed at any angle with the part above; for when so fixed and the brace secured to foot and leg, any inversion tendency is combated by the entire brace, which thus acts as

a powerful spring to keep the foot rotated outwardly. The second or pronation ratchet is to be placed where the side-strip passes under the shoe or insole (Fig. 4), and enables the surgeon to entirely prevent any tendency of the foot to turn under, for if the side-strip be clamped by it at an angle of  $45^\circ$  outward from the foot and then brought up against the leg and secured by the girths, the foot will be turned in its long axis so that the patient will walk on the inner instead of the outer side. This effect may be varied by the ratchet in the side-strip, so that the brace may be anything from a simple vertical support to an agent for the production of valgus, so completely does this ratchet place the limb under the control of the surgeon.

The third and last indication is combated by the use of elastic webbing, provided with hooks, passing from an eyelet in the sole opposite the base of the little toe to a point on the side-strip at about the lower girth.

The rubber webbing is preferred to the rubber cord, as used by Sayre, on account of its durability, and because the cord is apt to wear through over the ball of the hook, necessitating frequent renewal.

We thus, by means of this brace, place the foot in a position to properly receive the weight of the body; and, if it is so received, the weight becomes an agent for the permanent cure of the deformity, tending to press the foot into normal shape; but if, instead of being rotated outward, the foot received this weight while inverted, or in the median line, the deformity would be increased.

In many cases it may seem preferable to allow a limited range of lateral movement of the foot, instead of having the eversion fixed by the clamp.

This may be secured by having a

loose rotary joint and attaching a coiled spring to the side-strip, whose power can be regulated by a cog and catch, so that it may be "wound up" to any desired degree of rotary power, thus combating the inversion by a constant elastic force, without impairing support.

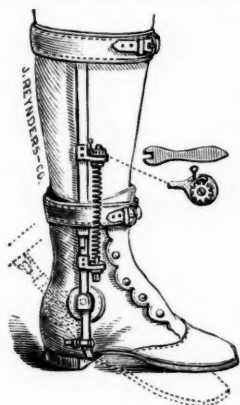


FIG. 5.

By either of these forms of apparatus we can mechanically combat any of the simpler forms of deformity presenting the symptoms detailed in the commencement of the paper; and for the after-treatment of club-foot which has been subjected to operation they fulfil every indication.

The physiological point to which I wish to draw attention is the necessity of rotating the foot outward (extreme eversion) before applying elastic force, if complete reduction of an equino-varus or an equinus be desired. Whenever, in these conditions, the os calcis is drawn upward and the astragalus projects, it is impossible to apply the upward elastic force advantageously in the median line until the foot is rotated outward, as the partial dislocation of itself prevents the normal degree of movement upward in the ankle-joint. The foot should be taken in the hands of the surgeon and forcibly everted, and, after passing the median line, pronated; and it will then be found that the deformity can be relieved with much greater ease. It therefore follows that a brace, to be effective, should contain provision for these movements, and afterward afford

fixation in the corrected position while not interfering with the normal motion of the ankle; and that braces have not done so in the past may perhaps be argued as one of the reasons why so many cases have been relegated to tenotomy, only to have the relief thus obtained often followed by relapse and an unsuccessful termination.

#### Case of Subcutaneous Section of Femur above Trochanter Major.

Dr. A. VAN DERVEER (*Annals of Anat. and Surg.*), believing that cases amongst which we would class the following are not so very numerous, I have thought best to report this one.

Miss P., aged nineteen, possessing a bright, happy expression of face and very cheerful disposition, through the kindness of Dr. S. Peters, of Cohoes, came under my observation first in September, 1881, giving the following history:

At the age of two years she fell down stairs, and shortly after she was noticed to turn slightly when walking, and soon complained of pain in the knee. She was treated for rheumatism. Three years after, the limb began to contract, and an extension splint was applied. Shortly afterwards, when the splint was removed, she fell again, injuring the same limb. After this, the joint underwent severe inflammatory changes, suppuration taking place, and finally ankylosis resulted.

At the time she entered the Albany Hospital—October 5, 1881,—the left leg was ankylosed at the hip-joint; it was partially flexed on the body and adducted, the knee being thrown in front of the right one. She walked by the aid of a raised shoe and cane, turning the whole pelvis, there being extreme mobility as well as a curvature anteriorly of the spine in the lumbar region.

When lying in bed, the leg was flexed and the curvature in the lumbar region very marked.



FIG. 1. LINE OF SECTION OF NECK OF FEMUR.

For the relief of the deformity which made sitting and walking so difficult, it was decided to do a subcutaneous section of the neck of the femur. October 10th, the patient having been put under ether by Dr. Mosher, assisted by Drs. Ward, Snow, Hailes, Van Derpoel, Jr., and house staff, I made an incision a little over the top of the great trochanter, and divided the muscles down to the neck of the bone by the use of Shradys's trocar with saw. So far, the operation was subcutaneous; but, on attempting to use the saw (which for a time gave us great embarrassment, trying to saw from within out, thus avoiding the femoral vessels), it broke off in the wound, necessitating its enlargement, which was done antiseptically under the

spray. The broken saw was removed with some difficulty, and the operation proceeded with, the section of bone being completed by an ordinary long, narrow, metacarpal saw.

It was found necessary, after the section of the bone, which was made just above the trochanter major, to perform tenotomy on the tendons of the adductor muscles.

Fig. 1, copied from a specimen in my private museum, Albany Medical College, gives a very fair illustration of the supposed condition of the joint and position of the femur; also the direction of the incision through remains of the neck of the bone.

Extension was then applied to the limb by means of the stocking and bandage, with about fifteen pounds weight, and kept up for about six weeks. A small abscess formed at the point of the tenotomy, but the wound over the trochanter healed kindly.

There was considerable oscillation of the temperature, it occasionally going quite high. This, however, gradually improved; and, at the end of about seven weeks, she was allowed to sit up, and soon after attempted to use the crutches. The condition at this time was about as follows: The limb is nearly straight with the spine when lying on her back, the shortening being only about one and a quarter inches.

July 12, 1883, I made an examination of Miss P.'s case, and found the improvement in her walk, the erect position she assumes in standing, and the ease with which she can sit down, and also bend forward in putting on her shoe and stocking, to be truly wonderful. The apparent curvature of the spine has disappeared. There is, without doubt, some motion at the hip, which she is sure is increasing. In walking, a stranger would scarcely notice any defect. The

limb has developed in size, and, as regards length, she wears the shoe of that foot raised only about half an inch.

#### Dislocation of the Knee and of the Hip.

In the *Brit. Med. Jour.*, Dr. J. W. HULKE reports an interesting case: A man aged 44 sustained a compound dislocation of the tibia and a simple dislocation of the femur. Suppuration set in in the knee-joint; amputation was performed, but in spite of it the patient died exhausted. This afforded the rather unusual opportunity of studying the pathology of dislocations of the femur.

At the inner side of the left buttock was an ulcer, from which a sinus extended through a ragged hole in the glutæus maximus, of the size of a sixpence, near the ischial tuberosity, to the hip-joint. In the substance of this muscle were several extravasations of blood, varying in size from that of a pea to a chestnut; and the space between this and the deeper muscles about the joint was filled with a grumous fetid fluid, composed of pus, broken-down clot, and gangrenous muscle-fibre.

The two other gluteal muscles and the piriformis were uninjured by the accident, but shared in the inflammatory softening which involved all the muscles around the joint. The obturator internus and the gemelli were lacerated, but they were not torn through; as was also the obturator externus. All these last-named muscles were extremely softened, so much so that much of their tissue could be washed away by a stream of water. The quadratus was entirely ruptured. In the inferior and posterior part of the capsular ligament of the hip-joint was an extensive laceration, crossed, and divided into two parts by the tendon of the obturator externus. The femoral

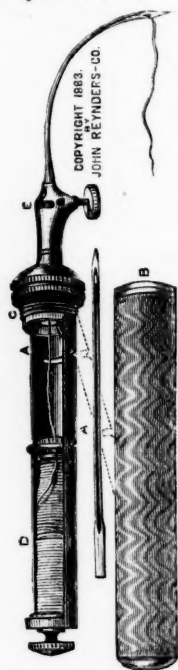
attachment of the ligament had been torn from the bone, leaving there only a fringe of its synovial membrane about a quarter inch broad, whilst its attachment to the acetabulum had been preserved. The ligamentum teres was ruptured, and through the laceration in the capsule the head of the femur could be easily slipped out of the acetabulum beneath the lower border of the obturator internus on to the dorsum, then resting there on this muscle and on the pyriformis.—*Med. and Surg. Reporter.*

#### The Combined Use of Thomas's and Furneaux Jordan's Laminated Splints.

After discussing their merits, in the *Brit. Med. Jour.*, Dr. E. STANMORE BISHOP concludes that the advantages to be gained by the combination of the two splints are: 1. It becomes possible so to lighten the weight of Thomas's splint that it can easily be borne by the weakest patient; and the weight of the laminated plaster is so inconsiderable, and so diffused over a large area, that the combined splints weigh about half the amount of an ordinary Thomas's splint, made after the original directions. 2. Whilst the Thomas's splint supplies the requisite impediment to flexion and extension of the hip, the laminated plaster supplies the firm grip of pelvis and limb, and forms an admirable *point d'appui* for any attempt at adjustment in cases of fracture. 3. The combination permits of a more certain fixation of Thomas's splint itself in any desired position; and it is not merely a safeguard against flexion and extension, but a very certain appliance for remedying excessive rotation, either external or internal. Of course, the patten on the opposite foot, the crutches, etc., are equally necessary, as they would be with the Thomas's splint alone.

**New Suture Carrier.**

An ingenious instrument known as "Goetz's Suture Instrument with Endless Thread," has recently been offered to the profession. It is shown in the adjacent cut :



This instrument combines in one, needle, needle-holder, ligature thread and disinfector. It consists of a hollow cylindrical part A D, holding at the end D a reel, upon which silk is wound, and to which at C the cap B is to be screwed. The hinge at C facilitates filling of the cap B with carbolized oil or any other disinfectant, whilst the part D of A D is in the cap. At C there is a washer which prevents leakage. The spool D is readily removable from its encasement, for winding silk upon it whenever the supply has been exhausted. Through C there is a perforation by which the silk passes out of A D and directly to the eye of the needle, which is near its point (in this respect the figure is incorrect—it appearing as though the needle was hollow, which is not the case). A straight and curved needle go with the instrument, either of which can be attached straight forward or at right angles with the same. It can be readily seen how, after once threading, this troublesome manipulation need not be repeated, regardless of the number of sutures to be made, as long as the supply of silk

holds out, which, when the spool is fully charged, is sufficient for several large operations.

**VENEREAL DISEASES.****The Pathological Changes in Gonorrhœa.**

Professor HAMILTON, of Aberdeen, has had an opportunity to examine microscopically the condition of the urethra in acute gonorrhœa (*The Practitioner*). The epithelium of the urethra is disposed much as in the bronchus, in three strata—the deepest of flat cells, the middle of pear-shaped cells, and the superficial of columnar cells. In acute gonorrhœa, the process consists mainly in an exaggerated and irregular proliferation of the deeper strata of cells, the cell-production being so rapid that the discharge contains but few of the fully developed columnar forms. The denudation of the surface in this process explains the scalding pain in micturition. The secretion of the mucous glands is increased, as in bronchial inflammation. There is also considerable corpuscular infiltration of the mucous membrane, leucocytes being accumulated in the sub-epithelial lymphatic spaces; and although there does not exist an elastic basement membrane, which, according to the author, prevents the escape of these interstitial products on to the free surface in bronchitis, he nevertheless doubts if that occurs here, believing rather that the cellular exudations in the meshes of the mucosa are carried away by the lymph stream. There was not in the specimen any marked congestion of the blood-vessels; and the trabecular tissue of the penis was not abnormal unless accumulated leucocytes in the cavernous spaces may be so considered. Strictures are produced in chronic urethritis probably by

the submucous tissue becoming cirrhused and contracting upon the lumen; the absence of "fixed joints" indicating the difference in results from chronic bronchitis when the tubes are dilated. The tubules of the testicles and of the epididymis from the same case also showed marked catarrhal inflammation, being filled with debris and epithelial cells in all stages of disintegration, but there was no interstitial inflammation whatever.—*Med. Record.*

#### Treatment of Phimosis by Dilatation.

Dr. ST. GERMAIN (*St. Louis Med. and Surg. Jour.*): The method of preputial dilatation extolled by Nelaton, has had variable results in the hands of operators, and this is the reason that it has not been generally adopted. Nelaton advised to pass a probe between the glans and the prepuce, in order to detect and to break up any adhesions; then to introduce a *three-bladed* dilator, to open it quickly and withdraw it while open. Many surgeons followed his example, and operated on a congenital phimosis, with success. But it has been severely criticised by many, owing to the occasional occurrence of considerable swelling and even of phlegmona; and they went back again to circumcision. But this bloody operation is not as innocent as it is supposed to be, and after having seen grave hemorrhage and diphtheria follow it, he returned to dilatation, only somewhat modified.

He used the ordinary *two-bladed* tracheotomy dilator, and had invariable success with it in thirty-four cases; in one case only, he failed, when using the *tri-bladed* instrument, the latter caused laceration and chafing.

Dilatation is justifiable in almost all cases of phimosis where the tissues are pliable and not altered. It will not

succeed when the mucosa is thick, fleshy indurated, or cartilaginous, which is sometimes the case. Circumcision then becomes necessary. Adhesions are usually found, the mucosa folds badly and cannot be turned over.

Dilatation is not a painful operation; assistants and anæsthetics can be dispensed with. The surgeon seizes the anterior border of the prepuce, while another may get hold of the posterior border, and the glans being exposed, the channel for the instrument is easily seen. It is unnecessary to pass the probe to break up the adhesions, the manœuvre being disagreeable and insufficient. The dilator is then plunged into the preputial cavity, up to the corona glandis, so that the extremity of the instrument should be felt through the prepuce. This is absolutely necessary in order to be sure that the dilator did not enter the urethra. When the dilating blades are separated, a sac is formed by the prepuce, resembling an hour glass, the narrow part of which is due to the condition of the mucosa; the skin is no factor in this. After dilatation is effected in one direction, the instrument is closed, turned, opened again and dilatation is practiced in the opposite direction. After this double dilatation the glans is seen. It is useless to break up adhesions; they give way gradually, and re-adhesion can be prevented by interposing borated vaseline. The two-bladed dilator causes neither chafing nor laceration. The patient should keep in bed several days, and apply a Goulard's solution to prevent swelling. Every day the glans should be uncovered in order to preserve the pliability of the prepuce and to prevent retraction. With these simple precautions, the results of the operations are always excellent.

### Preparations of Gold in Syphilis.

The *Med. Times and Gazette* says: In a discussion at the Société de Thérapeutique (*Bulletin de la Société*), Dr. MARTINEAU stated that in inveterate syphilis he had found preparations of gold very useful. He has given it with success in cases which had proved rebellious to mercurial frictions and subcutaneous injections. He prescribes the following mixture, giving three teaspoonfuls of it daily: Water, 1,000 grammes; chloride of gold, chloride of sodium, of each 1 gramme. Dr. Gengenheim, however, believes that the employment of gold should in these cases be quite exceptional; and some instances of their success should not divert us from the classic treatment of old syphilides by the iodide of potassium, which is thus far the most powerful and certain remedy that we possess. He always finds it of avail in deep-seated syphilitic lesions, and also in syphilitic affections of the eye. But it must to this end be given in massive doses, and in this way he has often ordered as much as ten grammes *per diem*.—*Med. and Sur. Reporter*.

### A New Method of applying Pressure to Enlarged Testicles.

Dr. J. L. CORBETT, of Lucknow, writes in the *Lancet*: In the treatment of some of the diseases of the testicle, accompanied with enlargement, the practice of applying pressure to the gland is undoubtedly a sound one, and is frequently resorted to by surgeons. I have often wondered that some simpler plan than that of strapping with plaster has not been suggested. The objections against the plaster strapping are numerous. First, it is a tedious business to do neatly and properly. Second, it is dirty, both for

operator and patient. Third, the operation has to be begun by encircling the neck of the gland with a long strip of plaster. This undoubtedly interferes with the free circulation in the vessels of the cord, and tends to prevent the absorption of the material deposited in the gland. It stands to reason that the freer the circulation in the vessels going to or from the testicle, the more rapid will the reduction in size be from the operation of absorption induced by pressure. Fourth, the strapping loosens very rapidly, and, to be of use, must be reapplied frequently. Fifth, in many cases, even when carefully applied, the plaster cuts the skin and leads to sores. Sixth, I have seen nasty, troublesome eruptions on the skin of the scrotum, following the use of the plaster. I have, I think, enumerated enough objections to the old plan; and I will now try to explain the means I would recommend for obviating these objections, at the same time applying a steady, equable compressing force, and one which would also admit of easy regulation as regards the amount of compression. I may preface the explanation of my plan by saying that I derived the idea from a homely source—nothing more nor less than seeing the means employed for incasing a football; barring that, instead of having the incasing material made of leather, I would have it made of India-rubber—such as one sees in the construction of the balls in spray-producers, etc. The cases I recommend should be made of different sizes and thicknesses, oval in shape (same shape as the Rugby football when inflated). The means of tightening the cases and applying the pressure would be identically the same as in the football cover—*i. e.*, by lacing. There should be an opening at the neck of the case to allow the passage of the cord. This opening

would be surrounded by a ring (interrupted) of leaden wire, to insure its patency and to prevent pressure on the structures of the cord. The leaden wire ring being interrupted, its softness would offer no obstacle to its easy adjustment round the neck of the enlarged gland. With a supply of the cases which I have attempted to describe above, the treatment of an enlarged testicle would offer but little difficulty; it would simply mean the selection of a rubber case of the right size and thickness, and capable, when laced up, of exercising a steady, equable pressure on the enlarged organs, and applying the case to the testicle and lacing it up. If considered necessary, the testicle could first be enveloped in a thin layer of cotton-wool; this would prevent any possibility of the skin being nipped or chafed by the lacing. As the gland reduces in size, a smaller case would be applied, and thus a steady pressure kept up until a cure was effected. The above plan has the advantages of simplicity, neatness, and quickness in its application, to recommend it. It involves no elaborate apparatus, and I think does away with many, if not all, of the objections connected with the operation of strapping with plaster.—*N. Y. Med. Jour.*

#### Collodion Dressing in Orchitis.

Dr. W. C. BOTELER emphatically recommends the application of collodion in cases of orchitis [epididymitis?]. He usually applies adhesive straps and then covers the whole with collodion, using about an ounce in each case, and applying it uniformly and smoothly with sweet oil to prevent the collodion from sticking to it. He claims very satisfactory results from the uniform pressure and suspension thus secured. He regards this treatment as most effective

probably in chronic cases.—*Kas. and Mo. Valley Med. Index.*

#### Gonorrhœa Easily Cured.

Dr. Z. T. DELLENBAUGH (*Coll. and Clin. Record*): In cases of acute gonorrhœa I have, for eight or ten years, used carbonate of lithia to alkalinize the urine; and find the five-grain compressed tablets, one taken three times daily, very convenient, fulfilling every indication better than any other salt. I now rarely find it necessary to give any other remedy internally.

Should the case fail to respond to the following injection, and not show marked improvement in two or three days, two sandal-wood oil capsules may be given, three times daily, for three or four days. The injection I have used in cases of acute and sub-acute gonorrhœa for more than a year, with the most gratifying results, especially to the patients, who have recovered in from two to seven days, and paid me from one to three visits, is the following: *R.* Resorcin, 3 j; acid. boracic, gr. xx; zinci acetatis, gr.  $\frac{1}{4}$ – $\frac{1}{2}$ ; aquæ destillat., f.  $\frac{3}{4}$  iv. *M.* Of this solution, two teaspoonfuls are injected three times daily. The germicides, resorcine and boracic acid, are so slightly astringent, that it requires the additional zinc salt to restore capillary tonicity. This injection is quite or nearly painless.

In the treatment of the later stage of sub-acute and chronic gonorrhœa, without stricture or granuloma as a complicating factor, I have had the happiest results follow the use of the following injection: *R.* Hydrargyri chloridi corrosivi, gr.  $\frac{1}{4}$ –ss; zinci chloridi, gr. ss–j; aquæ destillat., f.  $\frac{3}{4}$  viij. *M.* Sig.—A tablespoonful to be injected well down into the urethra, three times daily.

Corrosive sublimate injections are by

no means a recent addition to the list. The rationale of their use, however, is recent. As in the injection for acute cases, the germicidal constituent must be so sparingly used (otherwise it produces great pain and reactive inflammation), that I find it very advisable to combine a more astringent salt; and the chloride of zinc is the one I have selected, for obvious reasons. Without doubt, a mild injection of corrosive sublimate and chloride of zinc is destined to be *the* injection for sub-acute and chronic gonorrhœa.

#### **Oxaluria as a Cause of Spermatorrhœa.**

DR. W. H. DICKERMAN, of Olean, N. Y., sends us the following communication bearing upon the etiology of spermatorrhœa: "While there is a diversity of opinion as to the cause of spermatorrhœa and its local symptoms, it certainly must be conceded that there is an abnormal condition of the nervous system manifested in every such case. Crystals of oxalate of lime are invariably present in the urine of such persons; and as it is generally conceded that free oxalic acid in the circulation is poisonous to the brain and spinal cord, we have a possible cause which should not be overlooked. As an illustration of this condition, the following case is related: A patient, Mr. S. W——, aged twenty-nine, presented himself for treatment about one year ago. He had been laboring under great mental weakness for several months, and complained of a dull pain and a sense of uneasiness in the occipital region. He said he had frequent nocturnal seminal emissions. There was great irritability of the neck of the bladder, and frequent micturitions day and night. The passage of a sound revealed hyperæsthesia along the prostatic portion of the urethra and at the

neck of the bladder. He denied ever having practised masturbation or indulged in excessive venery. He was greatly emaciated. The urine contained in suspension a milky, tenacious, gelatinous substance and upon microscopic examination many spermatozoa were discovered. Crystals of oxalate of lime were present in abundance. Taking into consideration that in the oxalate of lime diathesis (oxaluria) there is a chronic poisoning of the brain and spinal cord, due to minute particles of oxalic acid in the circulation, I regarded the spermatorrhœa as of only secondary importance, and put the patient upon dilute muriatic acid treatment. In two weeks he returned and said he was well. An examination of his urine confirmed his statement, and he has not been troubled since. As a cure resulted under the acid treatment in so short a time, I was forced to believe that in this case there was no other cause than the oxaluria."

#### **DISEASES OF THE SKIN.**

##### **Eczema of the Scalp in Infants.**

Dr. LASSAR (*Gaz. Med.*) employs the following formula: Salicylic acid one, tincture of benzoin two, and vaseline fifty parts. A certain quantity of this is smeared over the scalp two or three times a day, after having washed the infant's head with soap and water. To soften the crusts and facilitate the cleansing of the scalp, Dr. Lassar recommends the employment of oil containing two per cent. of salicylic acid.—*Med. Times.*

##### **Cure of Obstinate Scrotal Eczema by Hoang-Nan.**

Hoang-nan is a vegetable substance of repute in Tonquin as a remedy

against rabies, the bite of venomous serpents, leprosy, and several other grave affections. It contains nearly three per cent. of brucine and a small quantity of strychnine. Dr. BARTHÉLEMY relates in the *Bulletin General de Therapeutique* a case of chronic eczema of the scrotum in which this substance was employed with most happy effect. The patient, a gentleman about fifty of years age, had suffered for ten years from eczema of the scrotum, perineum, and upper and inner parts of the thighs. He had consulted numerous physicians, and had tried every conceivable remedy without experiencing any relief. Dr. Geneuil, the last physician to whom he applied, having read of the efficacy of hoangan in leprosy, determined to try it in this case. The patient commenced with seven grains per diem, gradually increasing to forty-five grains a day, in divided doses. While taking these large doses he felt the physiological effects of the drug (muscular tremors, trismus, and vertigo), but persevered with the remedy, and was rewarded at the end of ten days by a perfect cure of his affection. The amounts taken were larger than had been advised by Dr. Geneuil. In all, five drachms were taken. The patient was seen eighteen months later, and had then had no return of the eczema.—*Med. Record.*

#### The Contagiousness of Eczema.

A correspondent of the *Boston Med. and Surg. Journal* describes the following case, asking if it was a coincidence. To us it appears more likely to be mistaken diagnosis. A., aged nineteen years, while living in New York, was attacked with acute general eczema. He returned to Boston, and slept a few nights with his brother W., and afterward with another brother, N. W. and N. were both seized with this affection, and

within a fortnight W.'s lady love also broke out with it. They were all healthy people, and had never before had any skin disease. Only two of the four were surrounded by the same hygienic conditions. Did one catch the disease from the other, or was it a coincidence? Duhring says: "Eczema is not contagious. It cannot be acquired from being in contact with or from handling the patient; nor can it be taken from the discharge."—*Med. Record.*

#### Depilatories.

Having been asked by several correspondents for a safe and efficient depilatory, we reproduce the following from the *Druggist*:

The strongest and most reliable preparation of this kind is, perhaps, the hydrated calcium sulphide obtained by supersaturating a thin paste of freshly-slaked lime and water with sulphureted hydrogen gas. For this purpose, sprinkle over 100 parts of good quicklime about 50 parts of hot water, and, when slaked, triturate with 200 parts of cold water. Now place into a suitable flask and pass into it the hydrogen sulphide generated from 300 parts of sulphide of iron and 200 parts of dilute sulphuric acid gradually introduced into the generator. This preparation must be immediately placed in small vials and securely sealed; but even then it will lose its virtues after a few weeks. This preparation, the composition of which is theoretically  $H_2CaS_2 + aq.$ , was originally recommended by Böttger, but is sometimes known as Martin's depilatory. The paste is to be spread over the hairy skin to the thickness of a sixteenth of an inch and allowed to remain for ten minutes, when it is removed with a wet sponge. If allowed to remain too long, ugly sores are apt to follow.

Another depilatory, known by the

Turkish name Rhusma (being employed by the voluptuous beauties in the harems, where etiquette demands *complete* nudity of the body with the exception of the head, from which the hair is not removed), is composed of—Quicklime, 50 parts; starch, 30 parts; orpiment, 5 parts. This is converted into a paste with water, and employed like the former preparation.—*Med. and Surg. Reporter.*

#### The Treatment of Warts.

VIDAL recommends bandaging the wart-covered hands in flannel and green soap. After a number of applications the warts become softened and can easily be removed.

#### Warts.

P. LUCAS-CHAMPIONNIERE reports, in the *Journal de Méd. et de Chirurg. Pratiques*, the case of a child eight years old which had a considerable number of warts on each hand (twenty-five to thirty), and in which a cure was effected in two months by Fonsagrèves' treatment, which consists in giving each day eighty centigrammes of calcined magnesia. Coincidences must always be carefully guarded against, but in the present case the cure is due to the action of the magnesia. This action, which appears totally inexplicable, has been demonstrated in a certain number of cases. The author calls attention to the close analogy existing between warts and certain epitheliomas, and asks whether magnesia might not give as happy results in cases of the latter.—*Weekly Med. Review.*

#### Dandruff.

℞. Aquæ, 12 ounces; listerine, 4 ounces. The above is the best preparation for dandruff and to promote growth of hair.—*Med. Brief.*

### DISEASES OF THE EYE AND EAR.

#### Treatment of Ophthalmia Neonatorum.

Dr. J. B. JOHNSON (*Med. & Surg. Reporter*):

The purulent stage of this disease shows itself in two or three days after birth, and is gonorrhœal ophthalmia of the new-born infant. It is caused by contagion, and never occurs unless the mother, at the time of delivery, suffered with a gonorrhœal discharge from her vagina. The inflammation is as active and rapid as that of gonorrhœal ophthalmia of the adult; but is more manageable, and is not so rapidly destructive of the textures of the eyes. The physician who has seen and treated many cases of this disease, soon learns that the treatment must be alterative internally, and soothing and slightly astringent externally; and that the routine recommendation of text-books of the application of solutions of such medicines as nitrate of silver, chloride of zinc, corrosive sublimate, and alum, to the inflamed eyes, not only do no good, but are absolutely injurious. When the young physician meets with his first case of this disease, and consults his text-books on the subject of its treatment, he finds the local applications recommended for it are presented in such a confused and uncertain manner, that he does not know whether it will be best to use one in preference to the other; or all, as recommended, one succeeding the other; and not having experience to guide him, his case is more apt to terminate with an injured cornea and defective vision, than with an uninjured eye. I usually prescribe: ℞. Potass. iodid., grs., xij.; aqua distil., ℥ iss.; syrup simplex, ℥ ss. M. S.—Shake well, and

give a teaspoonful every two hours to the babe.

As a wash for the eyes, I have found nothing better than: *R.* Zinc. sulphas; plumb. acet., aa grs. vj.; aqua distil.,  $\frac{3}{4}$  iv.; tinct. opii, gtts. iv. *M. S.*—Shake well, and after the mixture has settled, use the clear liquid. This should be dropped into the eyes every half-hour, or every hour or two, or whenever the babe arouses; and all matter should be well washed from the eyes and eyelids by it, and a bit of linen cloth wetted with the wash should be kept constantly applied to each eye.

I have the edges of the eyelids well anointed three or four times a day with: *R.* Red oxide of mercury, grs. ij.; vaseline, 3j. Mix; but before making an ointment, the mercury should be well pulverized.

I have learned by actual experience to recognize the internal administration of iodide of potassium to be invaluable in this disease; and under this plan of treatment the many cases of ophthalmia neonatorum that have fallen to my care, have uniformly terminated without injury to the structure of the eye, or impairment of the sense of sight.

#### **The Dry or Moist Treatment of Chronic Purulent Inflammation of the Middle Ear.**

Dr. L. S. OPPENHEIMER discusses the relative value of the dry and moist treatment of middle-ear inflammation, and advocates the former (*Louisville Medical News*). His method is as follows: The ear is first thoroughly cleansed by means of a syringe and warm water; it is then carefully dried, and the powder insufflated, or applied on a piece of cotton through the speculum, the cotton being allowed to remain for twenty-four hours. The cotton absorbs the fluids and prevents them from again irritating the external

ear. The powder may be insufflated through a goose-quill, care being taken to apply it to all parts of the cavity. The above is repeated daily for a few days, then on alternate days, then once a week for a week or two. The syringe is not required after the first two or three days. The agents which I employ in nearly all cases are iodoform and salicylic acid, the latter being applied daily whenever granulations exist; a few days after, iodoform is substituted. It is of importance that absorbent cotton be inserted after each application, and removed the following day. It is also a good practice to use the Politzer air-bag once or twice a week during the treatment, as it helps to dislodge inspissated pus, tenacious mucus, etc. In brief, then, thorough cleansing before each application, insufflation of dry powders, and keeping the parts as dry as possible between the periods of treatment, will, I think, cure nearly if not quite all of those cases in a much shorter time than any other kind of treatment.

#### **Membrana Tympani.**

Prof. KNAPP, of New York, advocates (*Archives of Otolology*) the use of a pellet of cotton, wet with glycerine, as an aid to hearing, in cases of defective membrana tympani. He sums up his experience as follows: 1. Cotton pellets, moistened with glycerine and water (1 : 4) and worn as artificial drum-heads, are a great aid to many cases of partial or total defect of the natural drum-head with or without otorrhœa. 2. Their therapeutical action in arresting profuse discharge on the one hand, and in preventing the mucous membrane of the drum-cavity from drying up on the other, is most valuable. 3. They protect, like the natural drum-heads, the deeper parts of the ear against injurious influence of the

atmosphere, etc. 4. In some cases they are quite indispensable, and may be worn for a lifetime with permanent comfort and benefit. 5. In other cases they are needed only periodically, according as the copiousness of the discharge or the exsiccation of the mucous membrane requires their action in the one or the other direction. 6. The period during which a pellet may be left in the ear varies with the condition of the parts. They should be changed frequently, i. e., every day, or every few days, so long as the discharge is considerable. They should not be worn at all, when the discharge is abundant or offensive. When there is no discharge, they may be left as long as they are comfortable (to the patient) and the hearing is good. So far as my experience goes, they are apt to become unclean in a week or two. They ought then to be removed, the ear cleansed either with dry cotton or cotton steeped in warm soap-suds, and new pellets introduced. 7. The management of the ear disease should remain in the hands of a physician until a stationary condition, either of slight or no discharge, has been reached. During the time the patient is under treatment, he can be taught how to cleanse his ears and remove and replace the pellets.—*Weekly Med. Review*.

#### Treatment of Corneal Opacities.

Dr. MICHEL recommends sulphate of cadmium, of the strength of two and one-half grains to the ounce of mucilage, as an application to opacities of the cornea. A camel's-hair brush, dipped in this wash, is applied to the centre of the spot and retained in contact with it for a few seconds. At first the application is made once a day, but after a while is repeated two or three times in the twenty-four hours. When

the pain grows less, the strength of the solution may be increased to five grains or even seven grains to the ounce. When the opacity is of recent formation, it rapidly disappears under this treatment; but when it is of old date the applications must be long continued.—*Revue Medicale*.—*Med. Record*.

#### Treatment of Granular Lids.

Dr. ARNOUX claims to have met with great success in the treatment of granulated lids by the following simple method: The lid is everted and wiped dry with a piece of blotting paper. The granulations are then touched very lightly with a crystal of sulphate of copper; and, immediately after, a smooth cylinder of zinc is passed over them. Then the conjunctiva is carefully dried again, and, as far as possible, the impalpable black powder which remains after the operation, is removed. The lid is then replaced, but not allowed to touch the ball of the eye for a minute or two. No subsequent cold applications are necessary, as there is little reaction if the operation be delicately performed.—*Gazetta Medica di Roma*.—*N. Y. Med. Jour*.

#### Cerebral Abscess with Bilateral Choked Disc; Basilar Meningitis and Perineuritis and Descending Interstitial Optic Neuritis

DEUTSCHMANN (*Arch. für Ophthalmologie*, xxix, 1) reports a case of this nature occurring in a boy aged nine and a half years. He regards the perineuritis and optic neuritis as the direct result of the meningitis which accompanied the cerebral abscess. The exudation which distended the intervaginal space arose from the perineuritis, and was of inflammatory origin, as there was no dropsy of the ventricles present. The fact that the inflammatory process was most marked at the ocular end of the optic nerve does not militate against the descending nature of the lesion.—*N. Y. Med. Journal*.

# **FRACTURES, DISLOCATIONS, INJURIES, TUMORS, ETC.**

## **A Report of Three Cases of Fracture of the Femur in Old People, with Remarks.**

Dr. OSCAR J. COSKERY (*Md. Med. Jour.*):

CASE 1.—Margaret E——, aged 75, while crossing the room, slipped on a tomato-peeling, and fell upon the right side. She was admitted into St. Joseph's Hospital on July 31, 1876. There was no swelling of any moment in the immediate neighborhood of the hip-joint, but she referred all her pain to that spot, and she could not lift her limb from the bed. There was no constitutional disturbance. The diagnosis of intra-capsular fracture of the neck of the femur was made, and the limb put up in the anterior splint. The patient did well and was walking in six months. On April 10th, 1878, she died of senility. A post mortem revealed the condition of

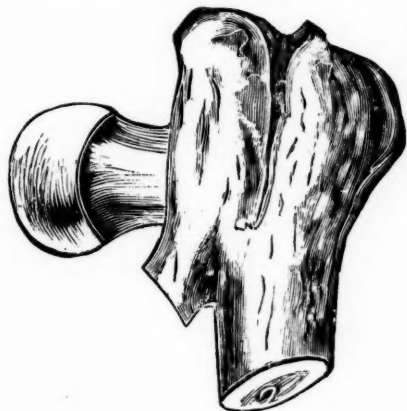


FIGURE 1.

the upper portion of the right femur shown in Figure 1.

The drawing might almost have been taken directly from Figure 179, Vol 1, of *Erichsen's Surgery*.

CASE 2.—Margaret S—— entered St. Joseph's Hospital on August 6, 1878, suffering from chronic bronchitis. She was then 83 years old. Nearly two years after entrance, or on July 2, 1880,



FIGURE 2.

on getting up at night to urinate, her foot caught in a piece of carpet by her bed, and she fell, striking the right thigh, first against the bedstead, and then upon the floor. She was helped into bed, and I saw her next morning. The diagnosis of extra-capsular, with probable intra-capsular, fracture of the neck of the thigh bone, was made. Very slight swelling, but pain and crepitus were present, and she died on July 7, 1880, seemingly from the shock of the fall. A post mortem revealed the condition shown in Fig. 2, or that of a comminuted fracture (extra-capsular entirely) of the neck of the femur, with longitudinal splitting of the great trochanter, as generally happens in these cases, and an extensive oblique fracture of the shaft.

CASE 3 is that of Elizabeth H——, aged 71, who first came into hospital for a compound comminuted fracture

of both bones of the right forearm, on October 4, 1881. Under the dry-lint treatment it was converted into a simple fracture, and she left, well, on January 9, 1882. Stepping from the flags to the curb-stone, on January 19, 1882, she again fell, striking upon the right hip, and was brought to St. Joseph's Hospital the next day. The thigh was little swollen; the patient's general condition was good, but she was unable to lift the limb from the bed, and upon examination crepitus was easily made out, with deformity, below the great trochanter. There was no difficulty in diagnosing extra-capsular fracture of the femur. The point was to decide if there was also an intra-capsular break. After careful examination, the latter was decided against. The patient was very unruly, but under the use of the Physick Splint pretty good union was obtained. On July 18, 1883, or eighteen months after the fracture of the femur, the limb was found to have fallen out of the bed; and when she tried to replace it, she could not without assistance. Mobility was distinct, with a slight feeling of crepitus. The patient slowly sank and died, August 20, 1883, or nearly six weeks after the last accident, seemingly of it and of old age.

Let us compare the symptoms as reported in these three cases with those given on page 434, Vol. 1, *Erichsen's Surgery*. They are as follows: Diagnosis between intra and extra-capsular fracture of the neck of the thigh-bone:

INTRA-CAPSULAR.—1. Cause generally slight and indirect, such as catching the foot in the carpet or slipping off the curb-stone. 2. Force usually applied longitudinally or obliquely. 3. Age rarely below fifty; most commonly in feeble, aged persons. 4. Pain and constitutional disturbance slight. 5. No

apparent injury to soft parts about hip. 6. Crepitus often obscure. 7. Shortening usually at first not more than one inch.

EXTRA-CAPSULAR.—1. Cause, usually severe and direct violence, such as falling from a height or a blow upon the hip. 2. Force usually applied transversely. 3. Age usually below fifty; chiefly in vigorous adults. 4. Pain and constitutional disturbance usually considerable. 5. Considerable extravasation, ecchymosis, and signs of direct

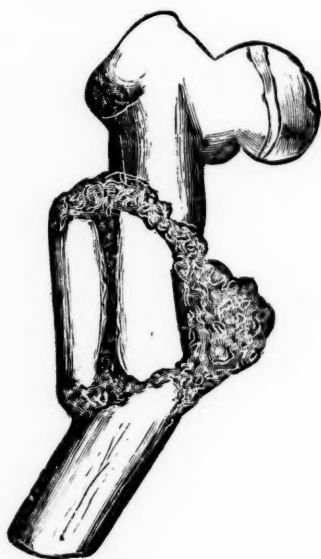


FIGURE 3.

injury to hip. 6. Crepitus (when not impacted) very readily felt. 7. Shortening (when not impacted) at least two inches or more."

As regards the first of the differential points spoken of by Mr. Erichsen, it will be noticed that one patient slipped upon a tomato-peel, one caught her foot in the carpet, and one fell while stepping upon the curb-stone. 2. It was impossible to decide from the statements of the patients in exactly what

direction the force was applied; possibly however, in case No. 2 it was directly transverse. 3. The ages of the three patients were respectively 75, 85 and 72, at the time of the reception of their injuries; the age *par excellence*, at which we would expect intra-capsular fracture. 4. While pain varied somewhat in these cases, with the exception of No. 2, it was very slight; and in her the shock from which she died seemed to be due as much to the general shake-up as to the injury to the hip. 5. There was in none of the cases any great amount of "extravasation, ecchymosis and signs of the direct injury to the hip." 6. Crepitus was easily made out in cases Nos. 2 and 3, but was not present in No. 1. 7. In only No. 3 was the shortening great, and in that it was but one inch and a half.

Two points may have attracted attention, and they are: first, that all three cases occurred in women: second, that each was upon the right side. I can offer no explanation of this, and consider it only a coincidence.

In No. 1 of these cases the diagnosis of intra-capsular fracture seemed correct at the time. The classical conditions that go to make up the predisposition to that form of injury were present. The sex, age, cause, slight constitutional and local disturbance, were all here. In the other cases, there was no doubt about the presence of *extra-capsular* fracture.

The acceptance of certain data of the olden authors in reference to the signs and causes of fracture about the neck of the femur has been one of the causes of the great difficulty in making a correct diagnosis experienced by the majority of practitioners. For instance, the change in shape of the upper portion of the femur that was said to take place in old age; and Ward, in his osteology,

has quite an ingenious and captivating chapter in which he compares the neck of the femur to a weakened derrick. Rodet has done much to disprove this idea by his measurement of the angle made by the head and neck to the shaft at different ages; and Bigelow has still further extended our sum of knowledge. That there has been no change in the position of the head in case No. 2 from what we generally find in the young, is seen at a glance.

Stimson, in his late work on Fractures, page 481, gives the post mortem appearances in six cases of fracture of the neck of the femur. Of these, only two were "purely intra-capsular." My principal object in contributing this small amount of personal observation to the profession is to call attention to the fact that in each of the cases, while the conditions in which we would expect one variety of lesion to follow were present, another occurred. In many cases in which the diagnosis of intra-capsular fracture has been made by myself, fortunately for the patient and my own personal vanity, the only positive proof was denied me—I mean, of course, a post mortem.

#### The Probable Cause of Non-union of Fracture of the Patella.

A good bony union in fracture of the patella is a desideratum, but one that is seldom vouchsafed to the surgeon. The cause, Dr. W. GEM thus endeavors to explain in the *Brit. Med. Jour.* He had an opportunity of making a *post mortem* examination on a man in whom a fractured patella showed no tendency to unite, and he found about three ounces of clotted and partly organized blood, pushing up the fragments, and so causing the displacement and non-coaptation of the fragments. The query arises, might not this clotted blood (or organized blood in the young subject)

be the cause of non-union in a great many cases, supposed to be due to the action of the triceps femoris? The case appears of interest, in clearly showing the line of treatment which should have been adopted, and the practical utility of early aspiration and putting up in plaster-of-Paris, so doing away with elaborate splints and lotions, and avoiding long confinement to bed. The case also shows the deformity and non-union produced by blood-clots from beneath the fragments, when apparently all effusion had disappeared.—*Med. and Surg. Reporter.*

#### Hereditary Predisposition to Fractures.

Dr. OWEN PRITCHARD reports to the *Lancet* the following case of hereditary predispositions to fractures: Mrs. M., in her recent confinement, was delivered of a well-developed male child on July 14th. On the 16th, the left humerus and femur of the infant were both found fractured about the middle of the shafts, without any history of accident or violence of any kind; and again, on the following day, the right humerus was found fractured in a similar situation, but this time the mother explained it by saying that she was moving her child in bed when the arm caught in the bed-clothes, and she felt the bone snap. On the 4th of August, the other thigh was fractured in a similar way, thus completing the round of the four limbs, all of which are undergoing the process of union. The child presents no symptoms of rickets. The mother has a good family history, but on the father's side there is a family history of fractures occurring spontaneously in infancy.

#### Iodoform in Compound Fractures.

Prof. MOSETIG, of Vienna, while irrigating the wound with pure water, removes all clots and spiculæ of bone and

coaptates the fractured ends, resecting them if necessary. After drying the wound, he throws a thin layer of iodoform into the medullary cavity by means of an insufflator. He then passes into the wound an emulsion of iodoform, for instance: *R. Iodoform subtil. pulv.; glycerini, āā 20.00; aq., 10.00; g. tragacanth, 0.15. M. Exact. f. emulsio.* This runs into all the little pockets of the wound.

The fragments are adjusted, metallic sutures being used when necessary; drainage tubes are introduced and the whole covered with a layer of iodoform gauze (50 per cent.) and this is covered with cotton. The first dressing can remain unmolested for three weeks or longer, unless fever occurs (the aseptic fever of the first day not included. With the above dressing, Mosetig treated successfully, within the last two years, thirty-seven compound fractures without even having noticed continued septic symptoms.—*St. L. Med. and Surg. Jour.*

#### Treatment of Pseudarthrosis of the Tibia.

Dr. F. GUERMONPREZ relates in the *Bulletin Général de Thérapeutique* a case of ununited fracture of the tibia cured by means of successive slight irritations of the opposing surfaces of bone, occasioned by the moderate use of the member. He concludes that in cases of this kind walking within appropriate limits is not injurious, and may even be conducive to a cure. The limb is to be steadied during use by means of stiff, well-fitting splints closely bandaged to the parts.—*Ibid.*

#### Rise of Bodily Temperature after Simple Fractures.

Dr. GRUNDLER has been making a series of thermometric observations in patients suffering from uncomplicated

fractures; and found in every case but one of those examined, a rise from  $2^{\circ}$  to  $4^{\circ}$  F. above the normal. The degree of fever is in proportion to the size of the broken bone, and to the degree of extravasation. The highest temperature observed ( $102.5^{\circ}$ ) was in a case of fractured femur, and the lowest ( $100.5^{\circ}$ ) in fracture of the forearm. The rise began on the evening of the first day, and reached its highest point from the evening of the second to the fourth day.—*Centralblatt für Chirurgie*.

#### Modified Plan of Reduction in Backward Dislocation of the Thumb.

Dr. A. B. HIRSCH (*Polyclinic*).

Difficulty in the usual means of reducing the above luxation, which I found in two cases, led to what seemed to be an easy and useful combination of two older methods—Crosby's right-angled motion, and the ordinary side to side extension and counter-extension. The combination proved entirely successful in both these instances.

The first case was that of a young man who, while trying to catch what is known in base-ball parlance as a "fly" ball—one falling from a considerable height—received it upon the palmar surface and end of the left thumb, causing a simple dislocation of the distal phalanx upon the dorsum of the adjacent phalanx. Extension and counter-extension were made unsuccessfully by hand, by the Levis apparatus (which latter had been used successfully in previous cases), by the clove hitch knot, by Charrière's forceps, and also by Dr. Crosby's plan of putting the opposing phalanges at a right-angle. Section of the ligaments having been proposed to the patient and objected to, I was compelled to resort to some other mode of reduction. Pulling on the dislocated phalanx, meanwhile steadying the next

one by my other hand, I by a sudden swinging outward, was enabled to tilt the *inner* and proximal angle of its base on top of the corresponding head of the next phalanx, by which an obtuse angle was formed. This position gave a purchase which easily allowed of complete reduction by manipulation, so that the usual after-treatment restored complete use of the joint.

In the second case, the injury was from the same cause and in the same position as in the first, but, unfortunately, complicated with oblique fracture downward and inward of the head of the second phalanx. Motion of the fragments rendered all attempts at reduction unavailing. The only alternative, other than section of ligaments or removal of bone, and these I particularly wished to avoid, was to try the leverage plan just mentioned, except that the fulcrum, in this instance, was to be the *outer* half of the head of the next phalanx. This was, after some effort, successful; and, although redundant callus delayed the cure, the man now finds no difficulty at working with the hand.

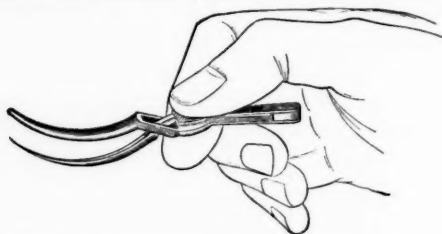
#### Retarded Union of Fractures in Diabetes.

In a communication addressed to the Academy of Medicine of Paris (*Bulletin de l'Académie*), Dr. VERNEUIL related the histories of several cases in which the union of fractures occurring in diabetic subjects was delayed, imperfect, or entirely absent. He referred to the theory of Bouchard, who classes diabetes among the disorders attributable to a retardation of the nutritive processes, and he thought that the cases observed by him were corroborative of this view. For the repair of wounded tissues is a form of nutrition, and any delay or fault in the reparative process implies a corresponding defect in the function of nutrition.—*Med. Record*.

**Hæmostatic Forceps.**

Dr. OSCAR H. ALLIS (*Medical News* of Sept. 1):

Under this heading I wish to introduce a series of instruments to the medical profession, that I have devised



for the arrest of hemorrhage; each instrument consists of two blades, under the command of a spring, the lower of which is a needle, and designed to transfix bleeding



No. 1.

tissues, which done, the grasp of the hand is released, and compression is instantly effected between the blunt blade which lies upon the surface of the bleeding vessels, and the needle which lies beneath them.



No. 2.

Its special application is where hemorrhage takes place simultaneously from many bleeding vessels. Few sur-

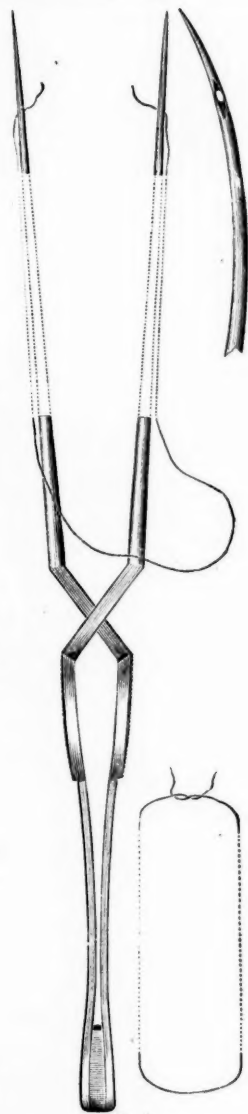


No. 3.

geons have not felt the need of a certain and instantaneous hæmostatic in operations in which the tourniquet cannot



No. 5, Small.



No. 4.

be used, or after the tourniquet has been removed. In the latter case, though the main vessels have been ligated, the hemorrhage is often so great from numerous small bleeding points and the usual means of arrest and ligation so tardy, that fatal collapse has not infrequently resulted. It is for this class of cases that the hæmostatic forceps have been devised. Beneath a bleeding area

the needle is thrust and the spring instantly denoting that the hemorrhage has been arrested, leaves the operator to turn his attention to another point of danger. Thus half a dozen well-selected instruments will be found as efficient, and much more transparent than a corps of assistants—not getting in the operator's way, and maintaining a silent but effective grip until the ligature may be applied, and the instruments one by one removed.

In the surgical clinics of medical colleges, in hospitals, in active military service, and in the private practice of those surgeons who cannot command adequate assistance this instrument will, I believe, be found of great service.

As hæmostatic forceps, they often render the ligature unnecessary, for no oozing will follow their removal, if the vessels are small and their application has continued for several minutes. In operating upon the female perineum, in which the ligation of vessels is to be avoided, this instrument, especially No. 1, will do excellent work.

Four varieties and eleven sizes are made; all accompanying diagrams are full size. Nos. 1, 2 and 3 will be found most generally useful. No. 1, or a larger size, will be found effectual in deep wounds, as in lithotomy. For plastic operations upon the face, a small size of No. 1 is made. There are three sizes of No. 1; three of No. 2, the largest of which is fully eight inches long.

No. 3 is a double-pointed instrument without eyes. This has a more general application than any single instrument of the group. In using any of the instruments, a quick firm thrust is neces-



No. 5. Medium.

sary, but this manœuvre can easily be acquired on the coat sleeve.

No. 4 is a double-pointed instrument with an eye in each needle point, and is designed to carry two ends of a ligature, beneath a bleeding area; and while the spring arrests the hemorrhage, the ligature can be secured, and the forceps withdrawn as in No. 4. The ends of the ligature should be passed from *without*, inward, as in the cut; and the mode of using the instruments familiarized by a little practice upon a piece of cloth, before putting it in actual service.

Although each instrument may be used not only as hæmostatic forceps, but also as a tenaculum, yet the two designed especially as tenacula are represented in the three sizes of No. 5. For this purpose, I have found the large size of No. 5 to work admirably.

My preference (if I could have but one variety) would be No. 3. For a full set for general use, I should take two each of Nos. 1, 2, and 3; one each of a larger size of same numbers; one of No.

4; one of No. 5, medium, and one of the largest size of No. 2.

No. 5, large, is a capital tenaculum.

I have given these instruments a satisfactory trial in the Jefferson Medical College clinic and hospital, and in the Presbyterian Hospital, and feel that they have a useful future before them.

**Case of Hernia, with Cysts unique in Character attached to Wall of Hernial Sac.**

Dr. T. F. PREWITT (*Annals of Anat. and Surg.*): Woods, colored, æt. sixty, had been troubled with an old inguinal



FIG. 1. CYST OF HERNIAL SAC.

A, main cyst, nearly natural size; B B, mouths of smaller cysts, with broom-straws inserted.

hernia of left side for years. On November 10, 1880, the hernia came down, and he was unable to reduce it. Symptoms of obstruction set in, with occasional vomiting. Dr. W. B. Nichols saw him and made efforts to reduce it, but failed. As the symptoms were not

urgent, temporizing measures were adopted until November 14, when, the patient being no better, I was asked to see him.

I found that there had been no action of the bowels for four days; that he suffered with paroxysms of pain, and had vomited occasionally.

The symptoms were still not urgent; no evidence of collapse; pulse good; no great tenderness about the tumor, nor was it very tense. It seemed to me I ought to succeed with the taxis in reducing it. I therefore proposed to give the patient an anæsthetic and attempt its reduction; but failing in this, to proceed at once to operate. This was concurred in by Dr. Nichols, and acceded to by the patient. Accordingly, after thoroughly anæsthetizing the patient, manipulation was carefully tried, but failed. There was something difficult to understand in the conditions.

It was clear there was no tension in the hernial sac, yet there was a resistance, an elasticity, and a fluctuation that suggested a co-existing encysted hydrocele. Against this was the fact that, in manipulating, the whole tumor seemed to be one continuous sac, and that no translucency appeared through the naturally dark scrotum. As there was no probability that there was a condition of the bowel demanding an opening of the sac, I determined to cut down and free the neck of the sac of all surrounding constriction, and reduce, if possible, without opening it.

This was done, but the same difficulty presented itself. The contents could not be made to pass through the neck of the sac. I, therefore, opened the sac; when the bowel could be seen looking perfectly healthy, except at the more dependent portion, where it was traversed by a white band, which, for the moment, was supposed to be lymph. A

touch showed that it rolled off the surface of the intestine, being entirely disconnected with it. It was puzzling. My left little finger was then introduced into the sac and carried in the direction of the neck, with a view of determining the cause of the difficulty in reduction.

The bowel immediately returned into the abdomen with the characteristic gurgle; my finger was then withdrawn, when there followed it a cyst, the size of

cyst, I found a very curious condition of things—something I imagine perfectly unique. Untying the ligature placed about the pedicle, I found within the main cyst two smaller ones, *with orifices opening into them from the outside* (Fig. 1, *B B*, and Fig. 2, *C*). I confess my inability to explain the phenomenon. What force could have acted to have produced secondary cysts with mouths opening into the hernial sac, while the

bodies of the cysts hung into the cavity of the main cyst, is inexplicable to me. Cysts within hernial sacs are rare, but have been occasionally found. From the silence of surgical works upon the subject, they must be extremely rare. Prof. Gross says: "In operating upon old strangulated ruptures the surgeon occasionally encounters an adventitious cyst, or a cyst formed by the obliteration of a part of the proper sac. Its contents are either serous or bloody, and its size rarely exceeds that of a small walnut.

The presence of the cyst in this case explained the difficulty in the reduction. Compression in the taxis was expended upon the cyst and made little or no impression upon the true hernial contents.

The contents of the cyst—a clear, transparent, serous fluid—were never placed under the microscope.

The pedicle of the cyst, when *in situ*, seemed about as large as a good big goose-quill, but when suspended by threads, and filled with water to be photographed, it presents a wide open mouth, as seen in the cut. The portion of the cyst just below the cut border presents a constricted appearance.

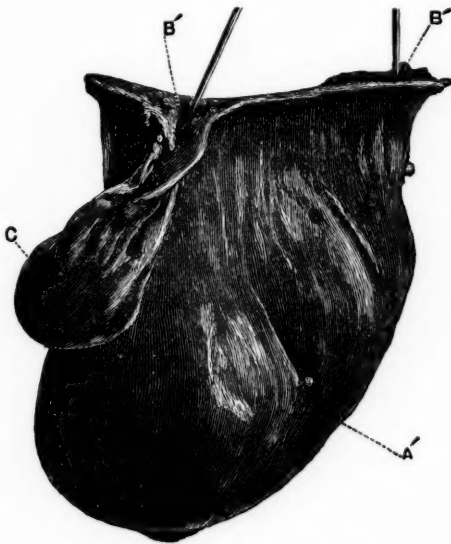


FIG. II. CYST OF HERNIAL SAC.

*A*, main cyst inverted; *B B*, mouths of smaller cysts inverted; *C*, larger of the smaller cysts inverted—the other smaller cyst is hidden from view, and is much smaller than this.

a hen's egg (Fig. 1), with transparent contents and a pedicle the size of a large goose-quill attached to the peritoneal surface of the inner wall—*i. e.*, the wall next to the pubis—of the hernial sac. The pedicle was tied and cut off, the wound carefully dressed, and the patient recovered without a bad symptom. The cyst, with the silk ligature about its pedicle, was placed in alcohol, and the bottle tightly stopped. Sometime after, when it occurred to me to examine the

**Removal of Wens without the Knife.**

Dr. CARREAUX removed a fatty tumor the size of a pigeon's egg from a young girl's foot by the following method, recommended to him by an old lady of his acquaintance: Frictions were made three times a day over the tumor by a mixture containing equal parts of hydrochloric acid and turpentine. The application was prolonged until the patient complained of a severe smarting. Then a plaster of hyoscyamus and mercurial ointment was spread over the part. The applications were made in this manner for eight or ten days, when signs of commencing inflammation appeared. They were then discontinued. A slight eschar formed at the most prominent part of the tumor; and, being thrown off, left a small opening through which the contents of the tumor were gradually extruded. When the sac was empty the walls became adherent through inflammatory exudations, and the cure was complete in a month or six weeks. The author regards this method as of value when the patients dread the knife, and when the tumor is small; but advises against its employment in the case of large tumors, owing to the danger of septicæmia arising from suppurative inflammation of the walls of the sac.—*Journal de Médecine de Paris.—Med. Record.*

**Treatment of Carbuncle by Scraping.**

In the *British Medical Journal*, Mr. H. B. HEWETSON read notes of a case of carbuncle occurring in an elderly patient, in which, on the eleventh day of the disease, he had made incisions, and then freely scraped away the diseased tissue, removing also portions of the affected skin by means of scissors. Having washed out the cavity with strong carbolic lotion, he filled it with lint dip-

ped in glycerine of carbolic acid, and applied an external dressing of salicylic silk. After three days, the carbolic dressing was discontinued, the silk alone being used. In fourteen days, the patient, a clergyman, was able to resume duty. Mr. Robson thought that the carbolic acid completed the cure by destroying the germs existing in the walls of the carbuncle.—*Med. & Surg. Reporter.*

**VENEREAL DISEASES.****Division of the Meatus Urinarius for the Relief of Locomotor Ataxia.**

At a meeting of the New York Medical and Surgical Society (*N. Y. Med. Jour.*), Dr. F. N. OTIS related the following case: Two years ago a gentleman consulted him with regard to incontinence of urine and some loss of motor power in the lower extremities. He was requested to see Dr. Seguin, who pronounced it undoubted locomotor ataxia, and gave a very unfavorable prognosis. He recommended the administration of large and increasing doses of ergot, and if convenient a course of treatment by the galvanic cautery. Dr. Otis recognized contraction of the meatus urinarius, and divided it, with the effect of producing almost immediate relief from the urinary symptoms. There was no history of syphilis, but, having recently read an article on locomotor ataxia, in which the iodide of potassium was highly recommended in the treatment, he administered the drug; and within a short time the man began to show decided improvement in the motor symptoms, and was at present almost perfectly well, and able to attend to his business as a gentleman farmer. Dr. Otis remarked that he had never failed in such cases to produce benefit by the

division of the strictured meatus if it existed.

#### **Manaca in Gonorrhœal Rheumatism.**

Dr. GEORGE HERSCHELL says in the *Lancet* that he has successfully treated many cases of gonorrhœal rheumatism with five minim doses every three hours of fluid extract of manaca (*Franciscea uniflora*). He has also used it in simple acute rheumatism, and his results have been equal to those derived from salicylate of soda, while in some cases, manaca has succeeded when the former has failed.—*Med. and Surg. Reporter*.

#### **A Three-Barrelled Penis.**

Dr. LUXARDO describes a rare anomaly of the penis which he observed in a young man under treatment for gonorrhœa. The meatus presented three openings, which corresponded to as many distinct urethral canals. The upper one gave passage exclusively to seminal fluid, the lower one to urine. The middle tube appeared to communicate with the lower one. The gonorrhœa affected only the two inferior canals.—*L'Union Médicale*.

#### **Polymorphous Changes observed in the Tubercular Syphilide.**

Dr. R. W. TAYLOR, in a paper based upon a case of syphilis presenting rather early the tubercular eruption described in the books as the non-ulcerative tubercular syphilide, said the eruption was general, symmetrical, and copious, had the characteristics of the secondary eruption, and, besides, all the deep-seated peculiarities of the tertiary eruption; so that, in order to place it in its chronological relation, it should be called what the French denominate the intermediate eruption. The patient was a man forty-seven years of age. Dr.

Taylor gave a detailed description of the changes which took place in the eruption, and illustrated them by colored photographs. At one period the eruption appeared strikingly like psoriasis, and subsequently like that illustrated by McCall Anderson, and maintained by Fox to be psoriasis rupioides, a condition which might give rise to the suspicion that what those authors had called psoriasis rupioides was only a late form of a papular or tubercular syphilide. The points of interest in the case were the following: 1. Its resemblance to psoriasis. 2. The colloid degeneration of some of the tubercles concomitantly with the increase of the granulation tissue in others. 3. The degeneration of the colloid tissue into pus, and the formation of bullæ. 4. The evidence offered that true bullæ might appear in a syphilitic subject, though they resulted from degeneration of tissue rather than from effusion of serum and pus, as occurred, as a rule in simple pemphigus. 5. The development of tubercles having thick, imbricated, conical, epidermal crusts like those of rupia. 6. The suggestion offered by these lesions that perhaps the psoriasis rupioides of authors was more or less dependent upon syphilis. 7. The formation of true rupia crusts from the bullæ above spoken of. 8. The fact that the non-ulcerated tubercular syphilide might be the starting-point of severe and extensive gummatous infiltration.—*N. Y. Med. Jour.*

#### **Treatment of a Simple Chancre by Heat.**

A member from Lyons read a communication before the Académie de Médecine on the treatment of simple chancre by heat. As the results of his experiments, he was led to consider that the employment of an elevated temperature was an excellent means of anni-

hilating the virus. The author recommended that a hip-bath should be given between 104° and 107°, and borne for several hours. He believed that this treatment would suffice to destroy the virus in twenty-four hours. In any case, it was certainly the best treatment of phagedænism and those chancres complicated with phimosis that no dressing can attain. It is needless to add that the doctrine of M. Pasteur as to the cause of virulent diseases has suggested this treatment.—*Medical Press and Circular*.

#### **Cactus Grandiflorus in Sexual Exhaustion.**

Dr. PITZER (*American Medical Journal*) says, that while other remedies are required to effect a permanent cure, nothing will give more speedy relief in this condition than cactus grandiflorus. It immediately strengthens the cardiac plexus of the sympathetic and improves cardiac nutrition of the heart. The pulse becomes regular. The expression is hopeful, and past sufferings seem to have been only dreams. It may be said that these symptoms are all secondary, and that cures cannot result from drugs prescribed at these. This is true, but no drug, no matter how effective in healing the original disease, can possibly effect its purpose so certainly and so speedily while the patient is laboring under the terrible nervous symptoms above narrated, which so quickly pass away under the influence of cactus. The primary disease has sometimes, to a great extent, disappeared, but continued long enough to excite the cardiac neuroses referred to. This secondary lesion has existed so long that it does not readily pass away, though the original disease be gone. Here the cactus is not only indirectly curative, but it cures in fact. In all these cases:  $\mathcal{R}$ . Tinct. cactus grand., 3j; aquæ,  $\mathfrak{z}$  iv.  $\mathcal{M}$ . Sig.

One teaspoonful four times a day. In some cases it is combined with pulsatilla, in others macrotys.—*Gaillard's Medical Journal*.

#### **DISEASES OF THE SKIN.**

##### **Notes on One Hundred Consecutive Cases of Skin Diseases Treated at the Philadelphia Polyclinic.**

BY DR. ARTHUR VAN HARLINGEN (*Polyclinic*).

The squamous form of eczema was represented by nine cases, all of which were met with on the scalp or about the face.

A little girl, two years of age, was brought by her mother on March 15th, with a history of a scaly eruption on the scalp, appearing at the age of six months and persisting ever since, in spite of various ineffectual attempts at treatment. The child had always been sickly. On examination, the scalp was found full of rather greasy scales, with more inflammatory action about the edge of the hair, and a red, weeping surface. I suppose that, owing to want of cleanliness, the peculiar seborrhœic, greasy condition of the scalp which exists in the first weeks of extra-uterine life had persisted, and the effete products of the skin allowed to remain in contact with the scalp had aroused the eczematous inflammation. The extension of the process had been favored by the child's unhealthy general condition. She was pale and flabby, though fat, and showed no signs of digestive disturbance. The following wash was ordered:  $\mathcal{R}$ . Acid. boric., 3 ss.; aquæ, Oss.  $\mathcal{M}$ . Returning after five days, the mother reported that the child's scalp was better, but I could see little improvement. The following internal treatment was then ordered:  $\mathcal{R}$ . Liq.

potassi arsenit., ℥xxiv.; aquæ, f ̄ iij. M. Sig. Teaspoonful three times a day. On March 7th, there was still not very much improvement in the scalp, though the child's appearance was better. The hair was then ordered cut short and the boric acid to be used in the form of an ointment: *R.* Acid. boric., gr. xv.; vaselini; ung. adipis, āā ̄ ss. M. Five days later the scalp was almost well, and as the patient did not subsequently appear, I have every reason to believe that she was cured.

The remaining cases were adults. One, a woman of forty-nine, in poor health, fat, but pale and flabby and of constipated habit, came on March 15th, with a squamous eczema of the scalp of not very long duration, but which alarmed her because it was accompanied by rapid thinning of the hair. The scalp was full of dry, greyish scales. There was some redness and scaliness in the skin behind the ears, which at times was moist and weeping. The patient was ordered three compound cathartic pills, to be taken the following evening; and then the next and subsequent mornings she was ordered to take the aperient tonic. Locally, she was directed not to wash the scalp at all, unless it became loaded with grease and scales, but to rub in a small quantity of the following ointment: *R.* Acid. tannici, 3 j.; vaselini, ̄ j. M. On March 20th she reported, much improved; and on March 27th, twelve days after beginning the treatment, she was nearly well, after which she ceased attendance, I think, because cured.

A cigar-maker, aged twenty-four, presented himself on March 17th, with an affection of the scalp which he said had existed in the form of "dandruff" for ten years, but had within the last few months assumed a different appearance. On examination a large circumscribed

patch of squamous eczema with abundant scales was seen to exist over the front of the scalp, the remaining portion being free from disease. The man was thin and poorly nourished, but not markedly out of health. As he suffered from constipation the usual aperient tonic was prescribed, with the following local treatment: *R.* Sulphur, 3 ss.; cosmolin, 3 iv. M. Under this treatment, rapid improvement took place. By the end of a week, the patient thought himself cured and was ready to give up treatment. I persuaded him to remain under observation for nearly two months; at the end of that time the scalp looked nearly well and there were no scales in it, although no ointment had been applied for a week previously. The patient was therefore discharged, but was given the following application, to stimulate healthy action in the scalp and to restore the somewhat diminished growth of hair: *R.* Acid. carbolic, ℥x.; ol. olivæ, f 3 iij.; alcoholis, f 3 v. M.

The remaining six cases were of little interest, either because the eruption was so slight as to be insignificant, or in several cases because the patient, after the fashion of dispensary patients, paid but a single visit.

Of erythematous eczema but two examples were presented, neither of which remained long enough under treatment to give any decided indication of its effects.

Eczema rubrum occurred in the persons of an elderly woman and two infants—perhaps the commonest victims of this affection, in public practice. The woman, who was fifty-five years of age, appeared for treatment April 2d, showing scattered hand-sized patches of eczema rubrum over the instep and calf and knee, on both legs. There was a good deal of infiltration, especially in

the patches over the instep, where the skin was thick, glazed, red, with little or no discharge and much itching. The patient was at first ordered the following wash: *R.* Pulv. calaminis; pulv. zinci oxidi,  $\text{āā}$  3 j.; glycerinæ, 3 ij.; aquæ, f 5 vj. *M.* This was to be applied to the various patches about the ankle, calf, etc., while the following ointment was to be diligently rubbed into the thicker patches over the instep and knee: *R.* Sulphur, 3 j.; vaselini; ung. aq. rosæ,  $\text{āā}$  3 ij. *M.* The patient did not return for nearly three weeks, and when examined showed so little improvement that a more stimulating treatment appeared desirable. She was directed to discontinue both of the applications above given, and to use the following ointment, well rubbed in at all diseased points: *R.* Picis liquidæ, 3 j.; hydrarg. chlor. mitis, 3 ss.; vaselini, 3 iij. *M.* Under this treatment, slightly modified from time to time, very marked improvement took place, and when last seen, on July 16th, the patient was on the high road to recovery. The time required for improvement in this case seems very long, but it must be remembered that three weeks were wasted at the beginning by the employment of a milder course of treatment, which was persisted in by the patient, without reporting to the physician. In private practice, where more energetic measures can be employed from the start, a few weeks would have accomplished all that was done here in three and a half months.

The other two cases of eczema rubrum occurred in infants. One was a slight case, where the disease occurred only behind the ears, and on the cheeks just in front. Black wash, followed by the application of a mild ointment of bismuth sub-nitrate, sufficed to effect a cure in about three weeks.

The second case of infantile eczema was one of those typical and severe cases which are occasionally met with where the disease is extensive, covering face, and involving also the limbs in places. The infant had suffered from the disease several months, and, although disfiguring, the eruption did not seem to cause much pain or itching. This is rather unusual, because it is the severe itching which usually gives the little patient so much anguish, and which involves a whole household, at times for weeks and months, in sleepless wretchedness. I could find nothing wrong with this child's digestive organs, and it seemed, except the skin disease, to be in perfect health. For that reason local treatment alone was at first employed, a saturated solution of boric acid being applied to the face, on cloths; and kept in apposition by means of a linen mask, being wet from time to time, day and night. On the body, a small quantity of the following ointment was applied: *R.* Acid. carbolicæ, gr. iij.; ung. zinci oxidi, 3 iv. *M.* Later, black wash, followed by bismuth sub-nitrate ointment, was used over all parts of the body. Occasionally, powders of calomel and sodium bicarbonate were given internally, but no other general medication was employed. After the greater part of the eruption had been removed by this plan of treatment, a slight relapse occurred, the lesions assuming a papular form, with considerable itching. For the purpose of combating this, the following prescription was substituted for the previous treatment: *R.* Olei cadini; olei olivæ,  $\text{āā}$  f 5 ss. *M.* To be applied with a feather twice daily. Under this treatment great improvement was made up to the time when the infant last appeared at the clinic, and I doubt not that it sufficed for entire cure.

Vesicular eczema was represented by two infants, neither of whom presented the disease in a very severe type. One was cured by the boric acid wash; the other required more management, especially with regard to diet—often such an important element in these cases.

#### Treatment of Eczema, Acne, etc.

DR. WM. T. CORBETT (*Ohio Med. Jour.*): For treatment of eczema the cases were divided into two classes: First, those in which the *irritant* was external, i. e. *local*; second, those in which the *irritant* was internal, i. e. *constitutional*. In the first class, local treatment only was employed, which of course varied somewhat with the case. In the acute stage, or when the parts were much inflamed, in both forms of the disease, the evaporating lotion of Hutchinson was used—the formula: *R.* Spiritus rect.,  $\mathfrak{z}$  vi.; liquor plumbi, B. P.,  $\mathfrak{z}$  iv.; aquam ad.,  $\mathfrak{z}$  xvij. *M. Ft. lotio.* To be effectual, the diseased surface should be kept constantly covered with strips of white flannel or lint, saturated with the lotion.

Tar, in the form of the liquor carbonis detergens, was quite extensively used, either diluted with water—two teaspoonfuls to a glass of water—to allay itching, or in the unguentum petrolei co. The following is the formula: *R.* Liq. carbonis deterg.,  $\mathfrak{z}$  ss.; hyd. am. chlor., gr. x.; vaselini,  $\mathfrak{z}$  j. *M. Ft. ungt.* But tar, although of great value in the chronic form, should be withheld during the acute stage, especially if much inflammation exists. Menthol was also used with good service: *R.* Menthol,  $\mathfrak{z}$  i.; zinci oleat,  $\mathfrak{z}$  ii.; vaselini,  $\mathfrak{z}$  j. *M. Ft. ungt.* When there was severe itching, carbolic acid or the oil of sweet almonds was added to the above.

In eczema marginatum of small area, the best results were obtained by dusting iodoform on the diseased surface, previously moistened; then covering the surface with flexible collodion. The advantage of this covering over gelatine is in the length of time it remains in place.

For *internal medication* arsenic was given before the age of puberty; after puberty, liq. pot. in doses varying from 10 to 20 minims. The whisky tincture of burdock seeds, as recommended for psoriasis by the late Dr. Reiter, of Pittsburgh, was given in two cases of eczema squamosum with good results. In the case of eczema pustulosum it did not benefit; and in one of eczema papulosum the large quantity of spirit seemed only to aggravate the trouble.

*Acne*, the most easily seen, and, therefore, apparently the most common disease of the skin, was seen in only seven cases. As to etiology, the patients were all unmarried, and the disease first appeared at the time of puberty, or subsequently. In two cases the disease had existed for three and twelve years respectively. The patients, both females, were habitually constipated, circulation languid, with cold moist hands and feet, which in winter had been troubled with chilblains.

The most obstinate case, however, occurred in a prostitute, aged 20. The disease—*acne vulgaris et indurata*—first appeared one year before she presented herself at the clinic, which corresponded in time to her becoming a *fille de maison de joie*. I could get no history of syphilis. The disease became decidedly worse just before each menstrual period. The genital organs were carefully examined, without finding any abnormality. In one other case—a bachelor aged 40—the disease was associated with sexual irregularities; and in

the remainder no definite cause could be found for the malady.

*Treatment.*—In one case of acne vulgaris, having existed three years in a girl aged 18, enjoying robust health, local means alone were quite effectual. She was directed to squeeze out twenty comedones a day; to wash the face thoroughly before retiring with hot water and soap, and the following lotion to remain on the face over night:  $\mathcal{R}$ . Sulph. precip.; spts. rect.; glycerini. Sig.—Calcis,  $\text{aa}$   $\mathfrak{z}$  j. M. Ft. lotio. Three weeks later, she returned much improved, and—to use her own expression—“was almost well.” She was ordered to continue as before. I have not seen her since, and believe her to be well.

In one of the cases mentioned when speaking of the etiology—the disease having existed twelve years in a female aged 26, with habitual constipation, moist hands and feet, a pasty skin and languid circulation,—I began treatment by directing a systematic course of diet, bathing, and exercise in the open air; the local procedures the same as given above. Internally: Mist. sod. et gent.; mist. magnes. cathart.,  $\text{aa}$   $\mathfrak{z}$  ss.; to be taken in glass of hot water one hour before breakfast. I saw the patient a fortnight later. She was having daily evacuations from her bowels, but otherwise there was little change. In addition, she was given liq. pot. arsenitis,  $\text{miv}$ , t. i. d. After a fortnight I saw her again,—one month from her first appearance at the clinic. At this time the disease was more active, and consequently more disfiguring, but her general health had improved, appetite good, bowels open; was taking cold sponge baths every morning, preceded once a week by a hot-water bath with soap. She was walking four miles a day. At her next regular visit there was a marked improvement. The arsenic was in-

creased to five minims, and finally to eight. She made a complete recovery. Time under treatment, eighteen weeks.

In the other case, with a condition similar, but where the disease had existed three years, the same plan of treatment benefitted during the first two months, but afterward had but little effect. She was, therefore, after four months' trial, ordered the following:  $\mathcal{R}$ . Iodoformi, grs. x.; acidi carbolici, grs. xxx.; vaselini,  $\mathfrak{z}$  j. M. Ft. ungt. Sig.—To be applied at night. In the morning, after washing the face, to apply with a soft sponge *lotio stimulans* of the Dublin Infirmary, which is composed of comp. tincture of benzoin, 15 mins.; solution of chlorinated lime, 15 mins. Internally to take pil. sulph. iodid. gr. 1-25 t. i. d. With this the patient began to improve, and three months later the disease had disappeared. In this class of people acne is common; it is also persistent; and in cases apparently identical requires, for successful treatment, a different medication.

#### The Bicarbonate of Soda

Is recommended by Dr. ROSSEAU as an external application in eczema. He uses it in the form of a pomade of the strength of fifteen grains of the soda to one and a half drachms of lard or other base. He holds that it alters the morbid anatomical elements of the skin and restores it to the normal state.

#### Intense Itching.

Dr. JAMES STARTIN (*Lancet*), recommends sponging the parts once or twice a day with pure rectified spirits, containing five minims of carbolic acid to the ounce.—*Med. and Surg. Reporter*.

THE AMERICAN MEDICAL DIGEST.

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PART III.

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Diseases of Women and Children,  
and Obstetrics.



# DISEASES OF WOMEN AND CHILDREN, AND OBSTETRICS.

## DISEASES OF WOMEN.

### The Essentials of Success in Ovariectomy.

Prof. A. J. C. SKENE (Proceedings of Kings Co. Med. Soc.): The first essential is to know how to operate—a self-evident proposition this, which need not be made here, were it not for the fact that many try to perform ovariectomy who are not qualified to do so. It is a notorious fact that this most important of operations has been performed by many who had no claim to being called surgeons.

It is clearly evident that one should be well grounded in the science and art of surgery before taking up ovariectomy. The consummate surgeon can readily transfer his art to this department of abdominal surgery, with far more hope of success than one who seeks to acquire skill by practicing ovariectomy as his maiden effort.

The best and surest way of all to qualify for this operation is to secure facility in general surgery, and then take lessons of some successful operator; to witness, and, if possible, to assist in a sufficient number of operations to see the different kind of cases and the various complications. By such means the surgeon can secure one great element of success, a knowledge of manipulations. Next to knowing how to operate is to obtain competent assistants.

Skill in diagnosis is a means of success of prime importance, and for many reasons should have been disposed of first; but I put the operation first in my argument simply because I believe that more

failures come from poor operating than from errors in diagnosis.

Ovariectomy, as an operation, differs so much with the different operations, both as regards the methods of procedure and results obtained, that I propose to notice some of the conditions upon which the success apparently depends.

In an operation of such magnitude the question of anæsthetics requires a passing notice. Sulphuric ether has still the best reputation. Its administration should be prompt and carefully kept up. The less ether that the patient takes the less the danger and the better the conditions of the patient after. Fifteen or twenty minutes wasted in anæsthetizing gives just so much unnecessary blood poisoning and to some extent retards recovery. Giving nitrous oxide gas first, and following it up with ether, is the most rapid way of anæsthetizing, and has given great satisfaction in some cases which I have seen. I have long been satisfied that the mixing of the expired air with the vapor of the ether to be inhaled, which occurs in the usual way of giving ether, is objectionable; so also is the low temperature of the ether vapor as usually given. It is, or has been, very difficult also to regulate the quantity of air to be admitted when it is desired to render the anæsthesia less profound. To obviate all these objections I have employed this apparatus. It is simply a reservoir constructed on the principle of the Ellis apparatus, to hold the ether and the long tube and inhaler used for nitrous oxide gas. By this arrangement the ether is thoroughly

vaporized and raised in temperature by passing through the tube. The expired air passes out through the escape valve, and the quantity of air to be mixed with the ether is regulated by the other valve. Pure air, or pure ether, or half and half, or any proportion of the two, can be employed in this way. I think it is the best that I have seen, but others may find that I am mistaken. There is, of course, nothing original about it, except in the adaptation of means already in use.

I will not dwell on the several steps in the operation, but only refer to some of the recent improvements in the management of complications.

First, in regard to firm adhesions. The forcible and reckless breaking down of these has given way to the practice of seizing them with compression forceps, carefully dividing, or breaking them and arresting all hemorrhage before losing sight of them. Again, in tumors that cannot be emptied by tapping, but require to be broken down, there is great danger from hemorrhage if there is much vascularity. This can be obviated by finding the pedicle and securing it temporarily with a compression forceps; a very important and life-saving procedure in such cases.

In the management of the pedicle we find that even the renowned operators do not all agree. Through the influence of the most successful of all operators, I am firmly convinced that the cautery gives the best results, and I am also satisfied that it is because the method of using it is not fully understood that it is not more generally employed. The object is to desiccate at least half an inch of the end of the stump and to avoid charring it. This can only be accomplished by strongly compressing the pedicle, using a heavy clamp, with blades half an inch thick, and then heating it with

a very heavy cautery until the portion in the grasp of the instrument is thoroughly desiccated. The stump thus treated looks like a piece of translucent horn. The divided ends of the vessels are completely closed, which guards against hemorrhage. I presume that the end of the stump does not slough, but becomes hydrated and finally organized.

The advantages of the cautery may be briefly summarized as follows:

It is a reliable way of controlling hemorrhage, it leaves the stump in a condition requiring the least reparatory care, and finally, it avoids all sources of irritation such as that which the ligature gives rise to.

I have recently employed a cautery clamp which, I think, has some merits worthy of notice. It compresses the pedicle on four sides. The long blades keep the tissues from spreading, while the short sliding blade presses the tissues against the other cross-bar. The advantage of this is that the pressure upon the pedicle is equal at all points, and it thereby gives a smaller stump. The trouble with the old straight clamp is, that it spreads out the pedicle too much, and while it firmly holds the central or thickest part, the outer edges are liable to slip out of its grasp.

The next and perhaps most important essential of success, is cleanliness, or, to put it technically, antiseptic methods of operating. Surgeons were beginning to feel a certain sense of security in performing ovariectomy when they carried out all the details of the Listerian method; but more recently they have found that carbolic acid in place of saving patients, sometimes sacrificed them. When the dangers of carbolic acid spray in ovariectomy were first announced, many surgeons thought that Thomas Keith had given up antiseptic surgery; but

that great surgeon is still as earnest and enthusiastic in his war against dirt as he ever was. Although he has given up the use of the spray, because he found the good that it did was counterbalanced by its injurious effects, he still retains all the other known elements of antiseptic surgery. These elements I understand to be, first, to keep wounds free from extrinsic germs, which are in themselves injurious to living tissues, or which favor morbid action in the tissues; and on the other hand to provide for the escape of morbid material which may be developed in wounds. To prevent the entrance of septic germs, perfect cleanliness of everything which pertains to the operation is necessary. The carbolic acid spray can at most only disinfect the air in the operating room, and consequently it is only one fraction of the antiseptic method of operating. Clean operators and assistants, clean instruments, sponges and everything which may directly or indirectly come in contact with the patient before, during and after the operation, are all of the highest importance. Still more, it is absolutely necessary to keep all things clean during the operation. A clean, fair start may be made; but during the operation the operator's hands and the instruments may become contaminated by contact with the contents of the cyst and the patient be exposed to septicæmia. This has often occurred when the spray has been fully and faithfully used. Indeed, if too much dependence is placed upon the spray, there is great danger of contamination from want of care in other respects. Some of the fluid contents of the cyst may enter the abdominal cavity, or the hands of the operator or his assistants may become soiled from the same source, and mischief may be wrought in that way. In short, it is exceedingly difficult to guard against all

sources of uncleanness in this complicated operation. I think, then, that if all the other essential elements of antiseptic surgery are carefully observed, the spray may be left out and still a high and perhaps the highest success can be attained. But spray or no spray, too much cannot be said in favor of antiseptics in relation to ovariectomy.

There is still another fact which stands out prominently, and upon which success depends, and that is the management of the dead material which may be unavoidably left in the abdominal cavity, or that may accumulate there after the operation. All the members of this society whose fellowship dates back ten years, must remember the paper read by Dr. J. Marion Sims, in which he pointed out the dangers of the bloody serum which so often accumulates in the abdominal cavity. They will also remember how he urged, with all the force of his genius and enthusiasm, the necessity of removing that often fatal material, by drainage. He at that time advocated drainage from the sac of Douglass through the vagina. That way has been supplanted by other and better methods, but what of that? his views were based upon the principles of the highest order of modern surgery, and to-day are held in higher estimation than they were then. It is true that within the last year or two there has been some difference of opinion regarding the value of drainage. The great men in London have laid it aside as a rule, while the lion of the North still employs it and insists that he saves many of his patients by it. When such great authorities are at war, the junior ovariectomists of Brooklyn may well pause to inquire what the results of this conflict will be.

By the dim light of a not very mature judgment and a very limited experience,

I can see that those who employ drainage have the best of it. I incline to this view because Keith, who practices drainage when necessary, still scores the highest number of successes; and because the reasoning against drainage by those who have given it up does not appear to fully harmonize with the facts in the case. It is claimed that if ovariotomy is performed with all the attendant means of antiseptic surgery, including the spray, any fluid which may be left or that may accumulate in the peritoneal cavity, is harmless. Spencer Wells states that either fluids do not accumulate after the use of antiseptics, or if they do collect they do not putrefy, but are absorbed without injury.

Now it is difficult to understand how antiseptics used in the operation could prevent the accumulations of serum in cases where there were many and extensive adhesions; and on the other hand, it is equally incomprehensible that carbolic acid in sufficient quantity should remain in the abdominal cavity and disinfect the fluids which transude from broken surfaces. Without daring to decide the matter, or to express any positive opinions, I may state that the truth appears to me to be this: Antiseptic operating will lessen the danger to a very great degree, but there ever will be cases which call for drainage.

The value of drainage depends largely upon the mode of using it. The method which I have usually seen practiced in this country is to pass a tube through the lower angle of the wound down into the sac of Douglass and closing the outer end of it. The cork is removed several times a day and the fluid pumped out. This gives a kind of intermittent drainage which is very imperfect. The method which I obtained from Dr. Keith is much better. In place of closing the end of the tube he passes it

through the centre of a piece of rubber cloth, and then places a carbolized sponge upon the end of the tube. The rubber cloth is folded over the sponge and tied securely with a string. The tube and sponge are thus excluded from the air, and any fluid which accumulates wells up through the tube, and is taken up by the sponge. The sponge is changed several times a day, and any residual fluid which may remain is pumped out at each dressing. In this way continuous drainage is kept up, and still a perfect antiseptic dressing is maintained. This may appear to be a simple matter, but it constitutes the difference between perfect and imperfect drainage. In a case operated upon last summer I obtained twelve ounces of fluid in thirty-six hours by this method of drainage, and the temperature of the patient never rose above normal, excepting one day when it reached one hundred, and remained there for a few hours. This case alone would be sufficient to demonstrate both the safety and value of drainage.

In addition to the requisite skill in diagnosing ovarian tumors, it is highly essential to success to make a correct estimate of the patient's general condition before operating.

An incipient disease of some of the organs of general nutrition may escape the notice of the ovariologist, and cause a fatal issue, no matter how skillfully the operation may be performed. Prominent in this regard is diseases of the kidneys. These organs should be carefully interrogated in all cases before operating. The same rule applies to all the important organs of nutrition, because any cardiac, hepatic, pulmonary, or renal lesions, although not marked or threatening the life of the patient, may still be sufficient to turn the scale to the fatal side after such a formidable operation as ovariotomy.

I well remember one case which illustrates this point. The patient was over sixty years of age, and appeared fairly well. Her nutrition was poor, it is true, but we suppose that that was due to the size of the tumor. During the operation, while trying to control the hemorrhage from adhesions high up in the abdomen, I caught a glance of the liver, which was far advanced in fatty degeneration. She lived a week, but died, as I think, from her hepatic disease, rather than ovariectomy. Had a more complete diagnosis been possible in this case, I would have had one less on the unfavorable side of my statistics.

#### Vaginal Ovariectomy.

Dr. W. H. BAKER reported a case to the Boston Society for Medical Observation (*Boston Medical and Surgical Journal*). The patient was placed in Sims' position, the posterior cul-de-sac opened, and the cyst drawn down to the vaginal incision and opened.

The writer's conclusions were that abdominal ovariectomy was always to be preferred to vaginal, except in the few cases (1) where the cyst is small and the contents bland, so that there will be little danger of any, and especially of septic matter escaping into the peritoneum; (2) of dermoid cysts small enough to be removed by the vaginal incision without evacuation.—*Med. and Surg. Reporter*.

#### Ovariectomy.

In a paper entitled "Notes on Abdominal Surgery" (*Dublin Journal Medical Science*, November, 1882), Mr. WM. STOKES sums up the following propositions in reference to ovariectomy:

1. That the mortality of the operation has been and is largely diminished by Listerian antisepticism, which should,

therefore, in all instances be employed.

2. That the strength of the carbolic spray should never exceed 1 in 40, and the solution in the steam-spray producer should be warmed previous to use.

3. That in order to get with greatest facility a warm, even aseptic atmosphere and the least disturbance, the operation should not be undertaken in the operating theatre of an hospital, but in a moderately sized ward, which should be given up for the time exclusively to the patient and her attendant.

4. That the intra-peritoneal method of securing the pedicle is to be preferred to the clamp.

5. That the "toilet of the peritoneum" should in all instances be carefully carried out.

6. That drainage should be recognized as one of the most essential features in the after treatment of ovariectomy cases.

7. That the existence of extensive peritoneal adhesions does not appear to influence unfavorably the results of the operation.

8. That in forming an estimate of the probable results of ovariectomy a greater value is to be attached to pulse than to temperature curves.

9. That the following precautions, emphasized by Dr. Atthill previous and subsequent to the operation, should be attended to:

(a) The administration of a mild aperient before the operation; (b) withholding solid food for 24 hours previous to the operation—allowing, however, beef tea, eggs, milk; and subsequent to it ice, milk and soda water, beef tea; (c) stimulants only to be given in cases of collapse, or in those of exceptional debility; (d) opium, either by the mouth or hypodermically should be given after the operation. The surgeon must ex-

ercise his own discretion as to the amount.

10. That pure ether is the anæsthetic that in most cases will be found to answer best.—*Maryland Med. Jour.*

#### Frequency of Diseases of the Sexual Organs in Insane Women.

Dr. DANILLO examined 200 insane women, and found that 162 or 80 per cent. were suffering from various diseases of the sexual organs. Out of 140 menstruating women, between 15 and 45 years of age, only 20 were without some uterine anomaly. Out of 60 women who had ceased menstruating between 42 and 75 years of age, 18 were the subjects of some affection of the genital organs. Acute and chronic endometritis and metritis were most frequently observed; less frequently displacement of the uterus, dysmenorrhœa, acute and chronic ovaritis, and other diseases. The above results show that the complications of psychosis with uterine disease is a frequent occurrence, and of the greatest clinical interest.—*London Med. Record.*

[We examined over two hundred insane women in the Asylum at Flatbush and found about 80 per cent. suffering from menstrual derangements, but not over 25 per cent. had any organic disease of the uterus. It will be seen that our observations differ widely from that of Dr. Danillo. More facts are still needed on this subject.] A. J. C. S.

#### Extirpation of a Mammary Adenoma with Continuance of the Gland Function.

Dr. JOSÉ ARMANGUÉ, in *La Independencia Médica*, reports the case of a woman, 30 years of age, who suffered from a large tumor of the breast. The integument covering it was normal, there was but little pain, and the axillary

glands were not enlarged. The tumor, an adenoma, measured when removed seven and one half inches in length and width by two and one half inches in depth. The nipple was situated in its vertical axis, at the level of its upper and middle thirds. This was dissected away from the tumor and left attached to the integument. After the healing of the wound all that remained of the mamma was a small portion of apparently atrophied gland tissue in the upper part. Two years later the woman became pregnant, when the breast began to enlarge, and, after delivery, secreted milk in abundance, the child being suckled indifferently with either breast.—*Med. Record.*

#### How to Deal with Uterine Fibroids.

Dr. WM. VARIAN (*Med. and Surg. Reporter*) describes his method thus:

After the usual primary incision of the abdominal walls through the linea alba, I proposed (a) to cut in the line of the original incision, through the capsule of the tumor; (b) to enucleate and remove so much of the fibroma as was convenient to the operator, and as could be done without endangering the patient from hemorrhage or shock, the amount thus removed being immaterial, as the taking away of a small portion assured the destruction of the growth as effectually as of a large; (c) to include the two incisions in the same sutures, and thus secure agglutination of the peritoneal surfaces; (d) after the expiration of a certain time, say from 24 to 72 hours, as the indications demanded, to remove so many of the sutures as were necessary to give free access to the cavity of the capsule; (e) by the combined use of therapeutical (ergot) and mechanical measures (the instruments and fingers of the surgeon), to remove

the fibroma from day to day, *piecemeal*, as it was loosened and thrust forward by the contraction of the sac; (f) when this was accomplished pare the edges and close the external wound.

I claimed that by this course the operator would secure—

1. The shortest possible incision of the peritoneum. No mean advantage, since statistics show that the danger in laparotomy is greatly increased by extending the abdominal incision.

2. The total exclusion of blood or irritating discharges from the abdominal cavity by the early agglutination of the peritoneal surfaces. This reduces the risk of peritonitis to the minimum.

3. Absence of severe hemorrhage, excessive shock, and the necessity of exposing or handling a great extent of peritoneal surface. This avoids the principal factors of danger in all operations for rapid extirpation of these tumors.

4. Facility of access to the tumor. The surgeon has it directly under his eye, and can insure (a) The prompt removal of the mass as fast as it is loosened from its capsule. This anticipates and prevents decomposition. (b) Thorough antisepsis, drainage, and, if necessary, irrigation of the sac. This removes almost all risk of septicæmia. (c) Perfect control over all tendency to hemorrhage. (d) Rapid extraction and removal of the fibroma by the mechanical and therapeutical resources of the surgeon.

#### Medication in Uterine Affections.

Dr. J. WARREN, Boston, recommends the following internal medication for relieving the engorged state of acute metritis:  $\mathcal{R}$ . Chloral hydrat.,  $\mathfrak{z}$  iii; chloral croton, gr. xxx.; liq. opii. com.,  $\mathfrak{z}$  vi.; glycerinæ,  $\mathfrak{z}$  ii.; syr. tolu.,  $\mathfrak{z}$  i.

M.—Teaspoonful every hour until ease from pain; and sleep is produced.—*Kansas Med. Index.*

#### Nymphomania and Hemorrhoids.

At the late meeting of the Medical Society of the State of Arkansas, Dr. W. H. HARDISON related a case of nymphomania, which caused a respectable young married woman to masturbate and to so deport herself as to cause the greatest family unhappiness. All drugs were powerless to relieve her. It was finally discovered that she was afflicted with very sensitive hemorrhoids, fissure of the anus and constipation. Operation and attention to the bowels so thoroughly relieved her that she almost went to the other extreme.—*Med. and Surg. Reporter.*

[It would be interesting to know what "the other extreme" is to which the young lady went after being cured of her disease and her bad habit.] A. J. C. S.

#### Coma During Menstruation Relieved by Venesection.

Dr. H. GOLDTHWAITE reported the following case to the Obstetrical Society of New York (*Am. Jour. of Obst.*): A woman suffering from uterine retroflexion and version suddenly passed, during menstruation, into a state of coma, without any apparent exciting cause. Various remedies had no effect. Finally, venesection was resorted to, when she at once began to regain consciousness, and went on to complete recovery. Examination of the urine gave negative results, and there had been no renal symptoms. She had never before lost consciousness.—*Ibid.*

#### Apparatus for the Treatment of Pelvic Cellulitis.

Acting on the principle taught by surgery, that the best way to produce ab-

sorption is by compression, Dr. PALLER described his apparatus for producing compression in pelvic cellulitis, at a recent meeting of the Obstetrical Society of New York (*Am. Jour. Obst.*): The instrument consists of a double water-bag, made of rubber, to rest over and below the iliac fossa on either side, and admitting of the use of a greater or less amount of hot-water pressure, according as the case might indicate. Counter-pressure could be made from within and below by the introduction of soft clay into the vagina, with the patient in the genu-pectoral posture. He had treated seven cases by this method, and the result in two had been very satisfactory. Of the other patients, two did not carry out the directions, two were still under observation, and one had been only five days under the remedies.—*Ibid.*

[We presume that the treatment here referred to applies to the products of pelvic inflammation rather than to acute cellulitis. Even so, we question whether absorption would be as promptly effected by pressure as by the normal motions of the pelvic organs, which aids greatly in disposing of exudates in the cellular tissue of the pelvis. Two "satisfactory" cases are not sufficient to establish the claims of the treatment.] A. J. C. S.

#### Menstruation and Pseudo-Menstruation in Different Forms of Typhoid.

Dr. E. BARRET, of St. Petersburg, has studied in a long series of cases the influence of various forms of typhoid on the phenomena of menstruation, and formulates his conclusions as follows:

1. The influence of typhoid fever on menstruation will depend upon the time elapsing between the onset of the disease and the menstrual period.
2. When the menstrual period falls within the first five days of the disease, the appearance of the menstrual flow

may be confidently expected; it occurred in 100 per cent. of his cases. If it is expected between the sixth and fourteenth days of the disease, it will occur in about 65 per cent. When expected after the fourteenth day, menstruation never appears.

3. The menstrual flow is suppressed more frequently in abdominal typhus than in other forms of the typhoid condition.

4. When present, the character of the menstrual flow is rarely altered in abdominal typhus; in spotted typhus (flecktyphus) it is usually diminished in quantity, and in relapsing typhus it is increased in amount.

5. The second and third menstrual periods rarely occur in any form of typhus.

6. Pseudo-menstruation, or a non-menstrual genital hemorrhage, rarely occurs; in spotted typhus it is a little more common, though it never appears before the age of puberty, or after the menopause.—*Deutsches Arch. f. klin. Med.*—*N. Y. Med. Journal.*

#### Extirpation of the Uterus per Vaginam on Account of Prolapse.

Dr. DUVELIUS (*Centralb. f. Gynäkol*) reports the case of a woman operated upon by Dr. A. Martin in Berlin. She was forty-six years of age, and had first menstruated at the age of seventeen. At twenty-two years of age she gave birth to a large child, the labor being normal. Thirteen days after delivery prolapsus began to be noticeable to her, and after a time it became excessive. The cervix was amputated afterward, and anterior kolporrhaphy was performed at one sitting, and posterior kolporrhaphy and perinæorrhaphy at another. The operations were complete failures; the parts projected to an exaggerated degree, and had undergone extensive

erosion and ulceration. In this condition she presented herself at Dr. Martin's polyclinic. Another anterior and another posterior kolporrhaphy were determined upon; but, when the patient was anesthetized, an entirely retroflexed uterus was found to be so completely surrounded by the remains of perimetric inflammation that total extirpation alone seemed practicable. After disinfection of the field of operation, incision was made around the remnant of the *portio vaginalis*, which was followed by free hemorrhage. The uterus was then drawn well downward, and an elastic ligature was placed around it. Douglas' pouch was next opened, as the uterus was detached at that aspect with scissors, knife, and fingers. In a similar manner the separation was made anteriorly. The uterus being now dragged forcibly downward, three ligatures were passed upon either side to secure the vessels, after which they were cut away. The stumps of the ligaments were brought down through the wound, and a series of both and superficial sutures was passed, securing the cut edges of the peritoneum and of the vagina. The operation was followed by peritonitis, but the patient eventually recovered. Anterior and posterior kolporrhaphy were subsequently performed, and the patient was believed to be entirely cured.

—*N. Y. Med. Journal*.

[Thomas Keith, of Edinburgh, has recently removed the uterus for prolapsus. The result was good, as most of his results are.]

A. J. C. S.

#### Leucorrhœa.

Dr. FORDYCE BARKER read a paper on this subject before the American Gynecological Society, on the 20th instant, of which the *Medical Record* gives the following resume:

It seemed to the author of the

paper that the fact that leucorrhœa was not a distinct disease, but a symptom of many different and even opposite pathological conditions, had led to a neglect of its study, and practically to a forgetfulness of the fact that it not rarely originates from constitutional causes, and that when long continued it becomes itself a cause of local and important pathological changes. No writer during the last quarter of a century had considered it, except incidentally, as a symptom of some local disease, with the exception of Comty Stoltz and Robert Barnes, who had called attention to some of its constitutional causes. This was equally true of Americans, English, French and German gynecologists.

For many years he was an entire disbeliever in the opinion of Tyler Smith that leucorrhœa was in many cases the primary cause of morbid states of the os and cervix, and while now he was not at all disposed to accept the statement that this is the fact in the majority of cases, in the last few years he has been convinced that it was true in some. While all accept the statement that local and constitutional causes continue to develop leucorrhœa, yet he thought it might be questioned whether the latter be not too often disregarded in the present day, both in the diagnosis and treatment of this disorder.

Many of these constitutional causes, such as atmospheric changes, which induce general catarrhal affections, plethora in some, anæmia in others, all forms of defective nutrition and debility, etc., were well understood. The influence of nerve disturbance, as a consequence of defective nutrition, was perhaps, not so generally appreciated, although most practitioners knew the fact that in some of their patients strong mental emotion was sure to bring on a troublesome leucorrhœa. Dr. Barker

then considered the bearing which certain anatomical facts, pointed out by Mayrhofer, had upon this disorder, namely, changes in the blood vessels of the uterus produced by pregnancy. Leucorrhœa and its attendant symptoms was not at all rare in young unmarried ladies, and every year he was consulted concerning it, chiefly by those who came to the city to "finish their education," as it is termed. The moral depression from home-sickness and exhaustion of nerve-power, exercised in accustomed directions, seemed to him to be the most common of the constitutional causes of these cases. He suspected the most frequent error in the treatment of these cases was found in a disregard of the necessity of such remedial agents as would secure a healthy performance of all organic functions, a neglect of the *morale*, and a routine prescription of some preparation of iron, which, under these circumstances, was sure to destroy the appetite and produce headache, etc. —*Mich. Med. News.*

[This paper comes in good season, and will, we hope, help to guard the gynecologists from a too rigid concentration of attention to local affections.]

A. J. C. S.

#### DISEASES OF CHILDREN.

##### The Last Thing in Incubation.

The *Lancet* is authority for the statement that M. TARNIER, of the Maternity Hospital, in Paris, has had constructed a box which is very similar to the incubators used for poultry. Into this he places all the weakly and sickly children.

This box is divided into two compartments, the lower one being used as a reservoir for hot water, while the infant is placed in the upper one, which is well stuffed at the sides and fitted with a

sliding glass cover. The temperature is maintained at 86 degrees, Fahrenheit, and M. Tarnier has found that by keeping infants in the incubator for a period varying from two days to six weeks their vitality is enormously improved. He has made experiments upon five six-months, children, six seven-months, and thirteen eight-months children, and he has only lost two of them, whereas, according to his statement, three-fourths of them would have died but for this adventitious aid to vitality.—*Med. and Surg. Reporter.*

##### Koumiss.

Koumiss, made at home, costs about fifteen cents a quart. The *Ledger*, of this city, gives the following recipe for its manufacture: "Fill a quart champagne bottle up to the neck with pure milk; add two tablespoonfuls of white sugar, after dissolving the same in a little water over a hot fire; add also a quarter of a two-cent cake of compressed yeast. Then tie the cork on the bottle securely and shake the mixture well; place in a room of the temperature of 90 to 95 degrees Fahrenheit for six hours, and finally in the ice-box over night. Drink in such quantities as the stomach may require. It will be well to observe several important injunctions in preparing the Koumiss, and they are:

1. To be sure that the milk is pure;
2. That the bottle is sound;
3. That the yeast is fresh;
4. To open the mixture in the morning with great care, on account of its evervescent properties;
5. Not to drink it at all if there is any curdle or thickening part resembling cheese, as this indicates that the fermentation has been prolonged beyond the proper time." Make it as you need to use it. The virtue of koumiss is that it refreshes and stimulates, with no after-reaction from its effects.—*Med. Record Ed.*

**Feeding with Dried Blood.**

M. REGNARD (*Lé Progrès Médicale* No. 23, 1882), suggests the employment of dried blood as food. In the case of six orphan lambs, three were fed on the ordinary vegetable food, and three on the same plus a certain quantity of cooked and dried blood. The first three dried, while the others developed splendidly. He remarked that if these results are confirmed, these economical results will be considerable, as it will permit the utilization of the hundreds of thousands of pounds of blood wasted in the slaughter-houses of Paris alone. He quoted a case of rickets in a child in which this food had given excellent results.—*Med. Record.*

**Micrococci in the Blood in Malignant Measles.**

Dr. KEATING, of Philadelphia, has been making some investigations with regard to the presence of micrococci in malignant measles, and their absence in the milder cases. He states that the moment malignancy appeared an examination of the blood showed micrococci in abundance in the field. He says that they not only obstruct the capillary circulation, but enter and destroy the blood corpuscles. Upon the strength of Dr. Formad's experience that *alcohol* most readily checked the development of micrococci in culture solutions, he withdrew the carbonate of ammonia and digitalis treatment and put his little patients upon whiskey in small and frequent doses, combined with tonic doses of citrate of iron and quinine, and the results were highly satisfactory. He alludes in this connection to the well-known efficacy of alcohol and calomel in puerperal septicæmia.—*Can. Lancet.*

**Renal Calculus in Children.**

The occurrence of renal calculus in children, Dr. EUSTICE SMITH thinks to be more frequent than is usually supposed. Uric acid is the commonest constituent of the concretion. This proteid derivative is often excreted in excessive quantity; an apparent increase in the amount being due to a diminished secretion of water, or an increased acidity of the urine, while a real excess frequently results from large quantities of food, or increased tissue-metabolism. This tendency to lithic acid formation may be hereditary, as in the gouty diathesis, and all conditions that interfere with the assimilative processes tend to a precipitation of uric acid in some part of the urinary apparatus, either as infarctions in the tubules of the pyramids, or in the pelvis of the kidney. Besides uric acid, oxalate of lime concretions are not uncommon in children; and sometimes small calculi of urate of ammonia or soda, occasionally a nucleus of uric acid, may be encrusted with urates or phosphates, the latter indicating the existence of vesical irritation. Urine that may be thick from lithates is passed without any distress to the child; but excess of uric acid determines frequency of micturition, signs of pain in the urethra, and very often nocturnal incontinence, while the passage of the sharp crystals along the renal tubules is a frequent cause of hæmaturia. Indeed, this latter symptom in children is usually to be attributed to the cause under consideration. Examination of the urine in these cases often gives a negative result. Calculus may exist in the kidney without giving rise to symptoms of any kind. Between the attacks of hæmaturia, the urine may contain neither blood nor albumen, and, unless uric acid be actually passing, it may redden litmus paper but faintly. Sometimes the irritation

produced by the presence of the calculus in the pelvis of the kidney may set up pyelitis, the stone then usually becoming enlarged by deposition of phosphates upon its surface. The passage of the concretion along the ureter seems to be attended with less pain than in the adult, though serious consequences will follow its impaction, such as contraction of the passage, and even hydronephrosis. While it is far from uncommon for children to pass quantities of uric acid sand, a coincident hæmaturia is by no means so frequent; and this seems due to the fact that the acid is commonly deposited from the urine in the bladder itself, and not at a higher point in the urinary tract. In the case of children, it may be laid down as a rule that renal hemorrhage, occurring in a child otherwise healthy, and accompanied by no symptoms or by hemorrhage from other parts of the body, is in the majority of cases to be attributed to the irritation of crystalline masses in the tubules, calyces, or pelvis of the kidney. Where there is evident disposition to excessive formation of uric acid the diet should be light and plain, and the meat and farinaceous constituents carefully proportioned to the digestive powers; alkalies should be given, and, if there be hemorrhage, perfect rest in bed enjoined. Styptics are rarely required.—*London Med. Record.*

### OBSTETRICS.

#### Placental Origin of Congenital Heart Disease.

Dr. VON HOFFMANN records a case of congenital closure of the semilunar valve. The child suffered at birth from cyanosis, atelectasis, and great irregularity of the heart's action, and died from suffocation on the third day. The

placenta had been previously examined and was found to be the seat of numerous recent and old extravasations. From these hemorrhagic foci pathological products had been introduced through villous absorption into the foetal circulation, and had thus given rise to endocarditis. The placental extravasations had been caused by violent fits of coughing, from which the mother had suffered about the sixth month of pregnancy, which date also corresponded to the beginning of the foetal endocarditis. Von Hoffmann advises the careful examination of the placenta in every case of childbirth, and believes that much light might thereby be thrown upon the etiology of diseases of the new-born.—*Transactions of the German Medical Congress—Med. Record.*

#### Ptomaines in the Amniotic Fluid.

The existence of a ptomaine has been demonstrated in the amniotic water. The fluid, obtained by puncturing the membranes during labor, was subjected to chemical examination by Mourson and Schlagdenhauffen, by whom the fact was reported recently to the Academy of Sciences at Paris. If the toxic character of this ptomaine shall be established, it may serve to explain some cases of miscarriage which may be caused by its presence in abnormal quantity. [As ptomaines have been shown to exist in normal urine, possibly the source of the pseudo-alkaloid here may rest with the fœtus rather than with the mother.—Tr.]—*La France Médicale—Maryland Med. Jour.*

#### Nineteen Months' Retention of Fœtal Bones in the Uterus.

Dr. SCHRAMM describes the case of a woman, aged thirty-two, married twelve years, who had had eight labors, the

first four of which had been normal; the last four had come at full term, but the children were born dead. The last labor was very difficult and lasted nearly four days. No post-partum hemorrhage followed, but the placenta, as well as all the cranial and some of the vertebral bones of the macerated fœtus, remained in the uterine cavity. Some weeks afterward there was an offensive discharge from the vagina, and, four months later, urine. During the last six or seven months the patient occasionally found small pieces of bone in her vaginal discharge. Having been called to see the patient nineteen months after her last labor, the author found her health deteriorated; there were fever, abdominal pains, constipation, and highly fetid discharge; the uterus was low down, and the os open, easily admitting a finger. The latter immediately came into contact with several friable bones of various sizes. The removal of them was accomplished without any difficulties, hemorrhage being slight. A vesico-uterine fistula existed. The general state of the patient soon began to improve, and the discharge of urine through the vagina considerably lessened.—*London Med. Record.*

#### Hyper-emesis in Pregnancy.

The author, Prof. M. HORWITZ of St. Petersburg, proposes the name of "Vomitus gravidarum perniciosus," applying it to a condition, which, from the beginning, exercises a decided influence upon the organism of the pregnant woman, which gradually grows worse, and results finally in a state in which the stomach rejects all food, liquid or solid. It is an emesis which may be called intractable, and continues until it ceases of itself, or ends with the death of the individual affected. He quotes from notes obtained in 186 cases, of which eighty-

three primiparæ and twenty-nine multipara suffered from this complication.

The notes regarding normal vomiting may be summed up as follows: 1. it occurs most frequently between the tenth and eleventh weeks of gestation. 2. It rarely makes its appearance suddenly. 3. But is preceded by a train of symptoms on part of the digestive organs, especially nausea, which are noticed as early as the third or fourth week.

4. There seems to exist a certain relation between the duration of nausea and the vomiting—the longer the period of nausea the shorter the emesis, and *vice versa*.

5. A similar relationship is noticed between the intensity of these two symptoms.

6. The vomiting of pregnancy is not identical with that caused by gastric disturbances; it is easily excited without causing much pain.

Horwitz now describes minutely twelve cases and their clinical symptoms. He divides the disease into two periods.

In the first period the duration of the nausea is relatively short, and if the appetite remains undisturbed, the emesis occurs several times daily, following immediately the introduction of food into the stomach. In multiparæ it occurs at irregular intervals and even when no food has been taken. One of the first results is a certain anorexia and a craving for victuals, which are digested with difficulty; rarely do they complain of thirst, but frequently of an irritable ptyalism. Diarrhœa is rarely met with. In the majority of cases he observes depression of spirits, even while the debility is slight. Many patients complain of a disagreeable odor emanating either from surrounding objects, or from their own persons (Hyperosmia), a symptom of great prognostic value. Such an hyperosmia, which has never been referred

to by other authors, Horwitz has observed frequently in a certain class of pregnant women and gynecological patients, while another class of patients, on the contrary, are fond of certain odors (*Pica olfactoria*).

In the second period of the disease the attacks of vomiting increase in frequency, growing almost continuous. They are very harrassing on account of the empty condition of the stomach. The mass vomited consists of mucus of a green color frequently mixed with blood. In consequence of the strenuous efforts at vomiting, the abstinence from food and want of sleep, there takes place a rapid loss of flesh and strength. Combined with these, there exists a distressing thirst, fear of partaking of all food and drink, obstipation sets in (*contra Rosenthal*), the quantity of urine is diminished and contains albumen.

Febrile symptoms are not observed during the first period, but later on in the course of the disease the temperature rises at irregular intervals, while at times it falls below normal. On the other hand, the pulse undergoes sudden variations. It grows more rapid (110-112), may be easily compressed, and grows fuller after emesis. The intellect remains unclouded in spite of the general debility, and only two or three days before death there occur paroxysmal attacks of delirium of a subdued character.

All of these clinical symptoms may be considered the results of starvation.

As concerns the etiology. Horwitz declares vomitus gravidarum pernicious to be an affection of the wealthier classes, since of his twelve cases but two were clinical material, and since during his twelve years' experience as director of the Marien-Gebärhause not a single case came under his observa-

tion. Thus may be explained the absence of statistics and the incredulity of hospital physicians in regard to this malady. We find by investigation that this hyperemesis occurs most frequently in France, next in England, and rarely in Germany.

Other conclusions are the following: Primiparæ are more subject to vomitus grav. pern. than multiparæ. 2. In a proportionately small number of cases is the vomiting to be regarded as merely a reflex symptom. 3. In the majority of cases the reflex vomiting continues until it becomes a pathological condition, as a consequence of advancing alterations in the sexual organs, especially the uterus. 4. Displacements of the uterus (*verses, flexis*) do not possess the amount of pathogenetic importance which some authors (*Graily Hewitt, etc.*) claim, but simply imply that certain pathological alterations have occurred in the uterine parenchyma. 5. These alterations consist of an inflammation of the organ. The inflammation of the neck does not exercise as much influence as that of the corpus and fundus. 6. Inflammation of the serous membranes is undoubtedly of pathogenetic importance in this disease. Probably this may be an explanation of this symptom (*hyperemesis*) in extra-uterine pregnancy. 7. The vomiting is connected in some cases with more or less severe pathological changes of stomach and intestines. 8. The greater the disturbance of the digestive apparatus the greater is the danger of the vomiting assuming an intractable character.

The prognosis varies according to the attacks and the duration of gestation. The hyperemesis runs a chronic course and is not primarily intractable. The prognosis is the more unfavorable the earlier the symptoms are manifest in the course of the pregnancy. Unfavorable

also in primiparæ (although it is not absolutely favorable in multiparæ). Criteria of an unfavorable prognosis are: Constant diminution in quantity of urine, presence of albumen, progressive emaciation, severe cephalalgia, increase in frequency of pulse, and finally apathy of patient.

The fatal termination is caused by marasmus or peritonitis. Cases have been reported, however, resulting in recovery, despite the above symptoms, but only after an abortion, which accident is of great importance. In the literature on the subject no statistics as to the death rate can be found, except by Joulin, who gives forty-four per cent., and hence it is surprising that some authors (Braun, Haussman, Ahlfeldt) offer a favorable prognosis. Of the twelve cases observed by Horwitz, in seven the pregnancy was not interrupted; of these, three died. In the remaining five abortions were produced, two dying. Hence in twelve cases we have five deaths.

Therapy: The legion of remedies (alkalies, alkaline waters, bismuth, laudanum, oxalate of cerium, sinapism, chloroform or ether spray upon abdomen and back, ice pills, iodide of potassium, bromide, nitrate of silver, electricity, etc.), is a proof of their inefficiency. Besides, they can be employed only in the initial stage of the disease. The author advises rest in the horizontal position in a darkened room; diet nutritious, but select.

Nutritive enemata may be employed, observing, however, the following rules:

1. One or two hours before their administration the rectum shall be thoroughly cleansed by injection of water;
2. But small quantities at a time, otherwise they will be rejected;
3. Avoid frequent use so as to avoid irritation;
4. When debility sets in add two or three tablespoonfuls of wine (sherry or port);

5. Should the enema be rejected add a few drops of tincture opii.

The gynæcological therapy is not to be neglected. If inflammation is present depletion is proper (by means of scarification; leeches being injurious). Nitrate of silver applied to the portio vaginalis is not of much benefit.

Should, however, all these remedies above mentioned prove without avail, but on the other hand the disease gradually increase in severity and the life of the patient in jeopardy, only one chance remains—to interrupt the progress of gestation; to produce abortion artificially. The earlier this procedure is adopted the more rational. Horwitz performs the operation in the following manner: After preparing the genital organs by warm carbolic injections and dilatation of the cervical canal by means of a tupelo, he separates the membranes from the uterine walls by means of a sound. Only in case of delay in the progress of the abortion does he rupture the membranes. In eight cases, in which he employed this method, he has not seen retention of membranes. The hemorrhage is slight, even less than in spontaneous abortion.—*Deutsche Med. Zeitung*.—*Cincin. Lancet and Clinic*.

#### Tetanus and Tetanoid Contractions After Labor.

A case of obstetrical tetanus occurring at the Maternity Hospital, New York, is reported by Dr. HENRY J. GARRIGUES, in the *American Journal of Obstetrics and Diseases of Women and Children* for October, and a careful review of the history of the subject is added, with tabulated lists of cases. The paper, however, is not merely devoted to puerperal tetanus, but considers tetanus and tetanoid spasms in their relation to any period of pregnancy, parturition and lactation. Although described by the ancients, the disease does not receive

much attention in our systematic treatises, because true tetanus is in America and Europe a very rare complication of the puerperal state, but, on the contrary, it is said to be very common in India. A hot climate is considered a predisposing element, and colored races are more liable to be attacked than white. As showing that infection has little to do with its causation, the fact is noted that it occurs more frequently in the country than in the city. Advanced age is a predisposing factor, and it seems especially that abortion in later years is dangerous. The liability after parturition decreases after the first pregnancy, that after abortion steadily increases with the number of pregnancies. Mental excitement, but especially hemorrhage (and of the form connected with retained fragments of placenta), early exposure to wet and cold, are named among the causes.

The symptoms do not differ from those of tetanus produced under other circumstances. It is of short duration and not infrequently fatal. Tetanoid symptoms, on the contrary, may be of hysterical or uræmic origin, are irregular in their course, and rarely dangerous. If due to uræmic, rheumatic or malarial toxæmia, the treatment will vary greatly from true tetanus, for which the administration of narcotics and antispasmodics is especially indicated. Chloral, bromide of potassium, or nitrite of amyl, and other remedies, are approved; the use of ice-bags to the spine, when the temperature is high, laxatives if constipation exists, disinfectant intra-uterine injections, and the use of a nourishing and stimulating diet, are chiefly recommended.—*Med. Times.*

#### **Puerperal Fever.**

In the *Edinburgh Medical Journal* for October is contained an interesting and

short paper by Mr. JOHN LOWE, on "Puerperal Fever; its Treatment and Prevention," in which occurs the following judicious expression of views in regard to treatment:

"I am strongly of opinion that by early and repeated aseptic intra-uterine injections, a rapidly-acting cholagogue, washing out the bladder, if necessary, with some aseptic solution, and the timely and liberal use of stimulants, will avert death in many instances. It is no use giving the nurse instructions to wash out the uterus; we must do so ourselves by means of a long tube in the uterine cavity itself. Ammonia and brandy I regard as the medicines for the disease; indeed, when food is refused, brandy is not only most grateful to the patient, but is peculiarly well adapted to supply the place of ordinary food, and no amount of fever or other symptom contra-indicates stimulation when changes so destructive to the vital fluids and tissues of the body are in terribly rapid progress. To give aconite or veratrum viride in such cases is, in my opinion, as unscientific as it is useless; and yet these remedies have been vaunted and are actually used by men of undoubted ability and eminence. To get rid of a fermentative poison from the blood, we must adopt some such practice as I have indicated, and not stop to theorize about the physics of the circulation. We must, in other words, support vitality and eradicate the poison. That salicylates and sulpho-carbolates taken internally do not rectify the turbid urine in puerperal fever I am convinced from experience; and I would strongly urge that all depressant remedies are both hurtful and dangerous."

The use of carbolic spray, and irrigation of the uterus and vagina with carbolic solution, immediately after labor, are considered important means for the prevention of puerperal septic poisoning.

## DISEASES OF WOMEN.

**Intra-Pelvic Dislocations of the Ovaries.**

Dr. CLINTON CUSHING, M. D. (*Pacific Med. and Surg. Journal*).

The intra-pelvic dislocations of the ovaries for all practicable purposes may be divided into, first, and by far the most frequent variety, backwards and downwards into Douglass' pouch; secondly, forwards into the utero-vesical pouch or that shallow cavity between the upper edge of the broad ligament and the bladder. Now as this cavity can only exist when the bladder is empty and contracted and becomes obliterated when that viscus is distended with urine, a displacement of the ovary into this location could scarcely exist unless it were fastened there by adhesive inflammation.

The causes of this affection are first, anything that produces relaxation or weakening of the parts that tend to keep the organ in position, the most common being repeated and frequent childbearing in a woman of lax fibre; the repeated pregnancy causing elongation and a flabby state of the broad ligaments precisely as it does that of the abdominal walls.

Any exhausting disease or any condition that produces a weak or relaxed condition of the general state, would be likely to affect the tissues of the pelvic organs in like manner.

Very thin women are more prone to this disease than fat women, and from this it would seem as if the absence of the padding of fat in and about the organs of the pelvis was one of the causes that led to it.

Displacement of the uterus backwards is a very common accompaniment of prolapse of the ovary into Douglass' pouch, and that the backward displace-

ment of the uterus should also cause a corresponding displacement of the ovary is only natural when it is remembered that the firmest support of the ovary is attached to the upper angle of the uterus. Marked prolapse of the uterus might also cause a displacement of the ovary downwards.

Habitual constipation and impaction of the descending colon with feces would, when there are accompanying predisposing conditions, tend to crowd the left ovary downwards.

Enlargement of the ovaries from any cause, would tend to produce displacement simply on account of the increased weight.

Adhesions between the ovary and the adjacent structures following pelvic peritonitis will sometimes drag the ovary from its place and fix it in an abnormal position. Falls or jarring of the whole body has produced dislocation of the ovaries.

The symptoms of this affection are usually sufficiently well marked. In all cases there is more or less pain and a sensation of dragging in the region of the prolapsed ovary, and there is usually pain in the corresponding hips and groin; these symptoms, however, being common to all forms of ovarian disease. But in prolapse of the ovary we have in addition severe burning and lancinating pain in the region of the displaced ovary at the time of and immediately following a movement of the bowels, the pain being worse if constipation exists. The pain is probably caused by the passage of the fecal masses over the displaced and tender ovary.

Menstruation is painful for the reason that the abnormal position of the organ causes more than the usual amount of congestion at the monthly period.

Sexual connection is nearly always painful and is necessarily so when the

ovary is low down in Douglass' pouch, and enlarged and tender.

Standing or walking usually aggravates the suffering.

In making a vaginal examination, if one, or if necessary two fingers are passed high up behind the cervix, the existence there of an ovary will be detected and is made more definite by depressing the anterior abdominal wall and with it the pelvic organs.

The ovary in this situation is always very sensitive to the touch and usually more or less enlarged, but may remain normal in size. It is elastic to the touch and unless fixed as a consequence of inflammation, can be moved without much difficulty but always with pain.

If the ovary is low down it can be compressed between the fingers and the sacrum, producing the dull sickening pain that is experienced by the male when the testicle is forcibly compressed.

A digital examination per rectum will enable you to reach at least an inch higher up into the pelvis than by an examination per vaginam. In obscure cases the rectal examination proves of great service.

The ovary may be mistaken for the existence in Douglass' pouch of a small mass of inflammatory exudation consequent upon a limited pelvic peritonitis. But in this case the fixation of the uterus and the recent history of symptoms of acute inflammation will assist in making clear the facts.

Sometimes small scybala in the rectum simulate a prolapsed ovary; but the absence of tenderness and the rectal examination will enable the examiner to differentiate between the two.

An enlarged and tender lymphatic gland situated behind the uterus would be likely to simulate a prolapsed ovary. But the lymphatic gland would almost surely be smaller than an ovary, would

be fixed and apparently a part of the tissues, and would be likely to be situated behind rather than in front of the rectum.

A small pelvic hematocele sometimes exists and causes pain in this region similar to a prolapsed ovary; but the sensation to the finger is wholly different and its rapid absorption and disappearance would enable us to make a correct diagnosis.

In an obscure case where it is difficult to make a diagnosis, the administration of an anesthetic will often enable us to make a thorough and satisfactory examination.

A question would naturally arise whether an ovary can remain prolapsed into Douglass' cul de sac and the woman remain in good health? Probably not, for the reason that the ovary would become more or less enlarged and hyperesthetic, defecation would become painful, and numerous reflex symptoms would ensue, such as infra mammary pain, pain in the top of the head, coccyalgia and disturbance of the whole sympathetic nervous system.

The prognosis must necessarily depend upon the length of time that the disease has been in existence, our ability to remove the causes, the size of the ovary and the extent of the fixation in the unnatural position.

If the displacement is recent, the ovary not enlarged nor complicated with pelvic peritonitis, and more particularly if the displacement is dependent upon a displacement of the uterus, the prognosis is good as to a relief of many of the symptoms, with a prospect of cure if the ovary retain its normal position under the use of a properly fitted pessary.

On the contrary if the affection is of long standing, the ovary much enlarged and tender or the general health seri-

ously impaired, the prognosis is grave as to cure, except by total extirpation. But many of the troublesome symptoms can be relieved by appropriate treatment.

The treatment must necessarily depend upon the cause producing the displacement and upon the condition the ovary is in at the time of beginning the management of the case. If the ovary is movable and there is no acute or sub-acute pelvic inflammation, have all constriction of the waist removed and put the woman in the knee-elbow position with the shoulders very low; now elevate the posterior vaginal wall with a Sims speculum and the vagina will become ballooned, and the uterus and ovary will fall forwards and upwards.

If the uterus is displaced backwards you can now easily draw it forwards, even into a condition of anteversion by means of a Simpson's sound. While the uterus is thus anteverted, by means of a ball of soft cotton held in the blades of a pair of long handled dressing forceps, crowd the post cervical cul sac upwards together with the ovary, and while the woman is still in this position, fill the vagina with a tampon of absorbent cotton, being careful to place several pieces behind the cervix at the beginning.

The woman can now turn on the side for a few moments and then get upon her feet.

This dressing can be retained for 48 hours and is usually worn with comfort and relief; and it keeps the ovary and uterus moderately well in place. It should be removed at the end of forty-eight hours and a large vaginal injection of hot water used and the dressing repeated. It will now be found that the ovary is higher up in the pelvis and is less tender.

This treatment should be continued for ten days or until the parts are in

a condition to admit of the adaptation of a pessary that will take the place of the cotton tampon.

If the ovary is enlarged and tender any manipulation must be conducted with the greatest gentleness, or the sufferings of the patient will be aggravated and the local irritation will be increased to such a degree as to render all local interference impossible.

If much enlargement or tenderness exists, confine the patient to bed for a week and have large injections of hot water thrown into the vagina night and morning; and at least once a day have the rectum filled with water as warm as can be borne comfortably. The rectal injections accomplish two objects, first, the removal of fecal matter, and second, the introduction of the hot water higher up in the pelvis than can be done per vaginam.

Painting the roof of the vagina immediately over the displaced ovary with the tincture of iodine every fourth day and then lightly tamponing the vagina, will assist materially in dissipating the chronic inflammation and enlargement. An ointment of iodoform applied on a pledget of cotton to the post cervical cul de sac and the tamponing applied below it is often followed by good results.

As soon as the ovary can be replaced with ease and the tenderness subsides, some appliance should be adjusted and steadily worn for a time to keep the ovary up out of Douglass' pouch, and to keep the uterus thrown forward. Nothing does this as well as a properly shaped vaginal pessary modeled after some one of the many varieties of the Hodge retroversion pessary. The most useful are the Gehrung retroversion pessary and the Thomas' retroflexion bulb pessary, with the posterior cross bar much heavier than in the ordinary Hodge pessary.

The adjustment of pessaries to these cases admits of the exercise of much ingenuity and skill, for it is not every case that can wear them.

The same general rules apply here as in the use of any form of vaginal pessaries; first, that the pessary must rest in the vagina sufficiently loosely to allow the finger to be passed up on either side, and the instrument must not cause pain to the wearer. And next, that while the instrument is worn the vagina must be kept clean by the use daily of vaginal injections, and the pessary removed at once if it causes pain, not relieved by rest and vaginal injections of hot water.

If these precautions are followed and the patient never allowed to let a month pass without having her physician make an examination, no harm would be likely to follow the use of the pessary.

Another pessary that I have found useful is Thomas' modification of the Cutter pessary, the instrument being removed at night; the use of this instrument sometimes preparing the way for the lever pessary, by pushing the fundus uteri well upwards and forwards.

While thus attempting by local procedures to restore and retain the ovaries where they belong, it is of the first importance to attend to the general condition and to establish as perfect a state of health as possible. See to it that a movement of the bowels occurs at least once a day. Regulate the functions of the stomach and liver if need be, and stimulate the action of the skin by systematized bathing and friction. Resort to tonics when indicated. The patient should be removed from the cares and responsibilities of a household for a time in order that the nervous system may regain tone. Sexual intercourse should be interdicted, for it is almost sure to do harm.

The bromides should be given to produce sleep when needed, and also for their well-known soothing and sedative action upon the ovaries.

For severe pain in the ovaries rectal suppositories may be used, containing *Cannabis Indica*, belladonna, iodoform or opium, but before these are resorted to I would ask the trial of large rectal injections of water as hot as the patient can bear. As an adjunct to this treatment let the patient loosen her clothing about the waist and then taking the tube of a Davidson's syringe, introduce it into the vagina, and then get upon her knees and elbows on the floor or upon a bed. The tube in the vagina allows the air to enter, the vagina becomes ballooned and the uterus and ovaries fall forwards and upwards and remain there as long as the position is retained. If now the woman turns gently over upon her side with a large pillow under her hip and the head and shoulders low, the effect is kept up without the patient getting tired.

In any case there is a decided advantage in having the patient lie down for one or two hours in the middle of the day; indeed I think the most of our American women would live longer and be healthier if they would make it a rule to lie down at least one hour every afternoon, and take rest as free as possible from mental and bodily labor.

In cases where the perineum has been destroyed I would advise its repair; and where the abdominal walls are lax, a well-fitting abdominal bandage applied across the body just above the pubes and kept from slipping up, answers a good purpose by taking somewhat the weight of the small intestines off the uterus and ovaries.

Where there is displacement of the ovaries due apparently to a relaxed state of the ligaments, I am of the

opinion that in addition to the improvement of the general health, electricity in the form of Faradism applied across the lower part of the abdomen will prove of value precisely as it relieves the atonic condition of the muscular structure elsewhere.

In cases where on account of enlargement or fixation of the displaced ovary, we are unable to relieve the condition, and the health and happiness, and it may be the life of the patient, are at stake, the question of removal of the diseased organ would be a legitimate one. I think in appropriate cases the operation is perfectly justifiable and would advise it in all bad cases that are incurable otherwise.

#### **Ætiology of Laceration of the Cervix Uteri.**

Dr. ELY VAN DE WARKER, in an interesting paper on this subject, deals very fully with the numerous pathological and mechanical causes of this affection, of which the following is a summary:

"A. Pathological changes in the cervix may lead to laceration during parturition from (1) progressive degeneration of tissues due to repeated labors; (2) cervical inflammation and hyperplasia; (3) degeneration of ovula Nabothi, or cysts or follicles degenerated into cavities; (4) softening due to chronic catarrh and inflammation; (5) presence of cicatricial tissue; (6) œdema of vaginal portion occurring at the first stage; (7) œdema due to heart disease.

"B. Deviations from the normal in conditions of the cervix antecedent to the labor due to general conditions as follows: arrested or impaired gestation, softening due to many causes.

"C. Deviations from the normal in the mechanism of labor: (1) want of balance between radial expansion of cer-

vical canal and elongation; (2) untimely expulsion with reference to cervical expansion; (3) excessive amplitude of pelvic strait, or (4) a small foetus permits too sudden expulsion; (5) adherent membranes; (6) sudden rupture of membranes, with rapid expulsion; (7) administration of ergot.

"D. All the foregoing conditions being normal, the cervix may be endangered from defect in the action of the uterus; (1) irregularity in action of the uterus [uterine polarity]; (2) disturbance in direction of descent of head of uterine obliquity; (3) harmony of uterine action disturbed by mental emotion; (4) hysterical state.

"E. Mechanical causes: (1) obstetrical operations; (2) vesical calculi; (3) long-continued distention by arrest of the head at the perinæum."

#### **Bromo-Menorrhœa or Offensive Menses.**

The odor of the normal catamenia cannot be said to be offensive, although it may be peculiar. It has been likened to that of marigold (*calendula officinalis*) and Virchow attributes it to fatty acids. Occasionally, however, this odor is extremely offensive and that too without the existence of appreciable subjective symptoms. The means for its correction are not very thoroughly discussed in standard literature, and this fact attaches all the more interest to an able paper on the subject by Dr. ALFRED WILTSHIRE, in the *Medical Times and Gazette*. He holds the increased activity during menstruation, of the sebaceous glands about the vulva, as largely responsible for the odor, but recognizes other causes. It is apt to be most offensive in the case of negroes and red-haired women. As a cause referable to the general system he mentions chlorosis and allied blood conditions. He has noticed the fact that in patients suffer-

ing from ozæna the nasal discharge becomes more offensive with the approach of the catamenial epoch; and the same he has observed in chronic otorrhœa and onychia maligna.

The local causes may be grouped as follows:

(a) Attributable to prolonged retention and decomposition of clots and other *debris*, due either to mechanical obstruction to the exit of the flow (stenosis or flexion), or to deficient expulsive action on the part of the uterus, often accompanied in either case by a scanty flow. (b) To the character of the discharges in certain morbid conditions and growths within the body of the uterus—for example, in subinvolution, particularly of the placental site—after abortions or confinements; in papillomatous and other diseases of the endometrium; in polypi, fibroids, sarcomata, epitheliomata, and other malignant growths of the interior of the uterus, usually where the discharge is not abundant, for if there be hæmorrhage enough to keep the *débris* washed away, decomposition may be prevented, except where fœtor comes on only on the subsidence of the flow. It is also an occasional, though rare, sequela of gonorrhœa, and that it accompanies certain degenerations of the endometrium.

In treatment, Dr. Wiltshire has found the syrup of the iodide of iron to yield the best results in chlorotic women; he often combines it with *nux vomica*. As adjuvants, and having more direct reference to the odor, he administers, unless otherwise contra-indicated, boracic acid, the sulpho-carbolates, salicin, quinine and iodine, although he is free to admit that the results from such remedies are not strikingly good.

It is obvious that when there is a mechanical obstacle to the escape of menses the remedy consists in overcom-

ing it by appropriate measures. When there are grounds for believing the offensiveness to be due to retention of the menses from defective expulsion, oxytocics may be given—as quinine, cinnamon, borax, ergot, viburnum, and such like. When there is no obvious blood impairment a suspicion of local trouble may be justifiable, and indicate exploration where it is admissible. But this is not always permissible and should be refrained from whenever it can properly be avoided.

As regards local measures other than operative procedures (such as erosion, removal of morbid growths, and dilatation) injections and irrigations with odorising materials are very useful. Solutions of boracic acid, sulphurous acid gas, carbolic acid, iodine (one fluid drachm of tincture of iodine to five fluid ounces of water, or stronger) and such like may be employed. Intra-uterine treatment of any kind, whether by injections or otherwise, should be employed with extreme circumspection at all times, and especially at the catamenial epochs. The intervals between the catamenia should be chosen for operative measures whenever these are indicated.

In virgins, in whom injections or similar procedures are inadmissible, and indeed in all cases, the offensive odor may be to some extent concealed and annoyance lessened by the use of charcoal in the diaper. Pieces of animal charcoal may be infolded in the diaper, or may be placed in a muslin bag, and applied in the usual manner.

Iodoform mixed with eucalyptus oil may be useful in certain cases, *e. g.*, in morbid growths; and when applied to the summit of the vagina, or near the seat of lesion, controls the trouble pretty effectually.

Pledgets of cotton-wool soaked in

glycerine with boracic acid (or boro-glyceride?) are highly efficacious; they excite a watery flux, but have a decidedly sweetening influence. Intra-uterine medication is only to be undertaken with every precaution, and should be resorted to only in refractory cases not admitting of other means of relief.

The caution must not be omitted, that in some married patients who are thus afflicted the acrid discharges excite urethritis in the husband if intercourse be indulged in near the periods. Much mental as well as bodily distress may be thus created, and unjust suspicions aroused.

Should offensive catamenia coexist with secondary eruptions or other signs of the syphilitic cachexia, the cause and treatment are, of course, at once suggested.—*Med. Age.*

#### Hysterectomy, Porro's Operation—Recovery

Dr. T. SAVAGE reports a case of a married woman, 25 years of age, whose health had been good until March 18, when she had vomiting and constipation, and an abdominal tumor was found upon examination. The uterus appeared to be quite distinct from the tumor; there was a sulcus between it and the cervix, and pressure from above did not affect the cervix. For reasons discussed in the paper, it was decided to operate, with the assistance of Dr. Dukes. The reporter says:

"On the following morning, therefore, Dr. Dukes giving ether, I made an incision nine inches long, the upper portion extending nearly two inches above the umbilicus. The tumor was found to be a large solid fibromyoma growing out of, and forming part of the right side of, the uterus. The cavity of the uterus was found to contain a fœtus, and was pushed upwards and to the left.

The right ovary and Fallopian tubes were in front of the tumor and almost black from compression between it and the abdominal wall.

"It was thought that it would be safer and easier to remove the whole mass, which was accordingly done, rather than attempt removal of the tumor alone. The stump was secured by a wire clamp, and its serous outer surface was attached by silk to the abdominal wound. Two thick silk ligatures were also tied round the stump for security. Very little blood was lost, and much care was taken to prevent any from being left behind the bladder or on the vaginal roof, which appeared to be considerably dragged upwards by the clamped stump. A glass drainage tube was inserted just above the stump, and perchloride of iron was applied to the end of the stump. After the operation, which lasted about an hour and a half, the finger passed into the vagina detected the cervix high up, but otherwise normal, showing that the wire had encircled the uterus at about the level of the inner os and had not included any of the vaginal roof with danger to the ureters. Only about four ounces of ether were administered. The mass removed weighed nearly nine pounds, and contained the fœtus with membranes intact. The recovery after this formidable operation was uninterrupted, and is very largely to be attributed to the care and skilful treatment of Dr. Dukes, who had the sole charge of the patient after the operation. She may now (August 25) be said to be quite well. The breasts secreted milk on the fourth day. The clamp came away on the twenty-first day.

"This is the second time that Porro's operation has been successfully performed in this country, so far as I have been able to learn. The first case was, very curiously, done by Mr. Knowsley Thorn-

ton, at the Samaritan Hospital, the day before this one (see *British Medical Journal*, July 22), and it seems to me that it ought to be more generally successful than the records from abroad show it to have been. Dr. Alexander Simpson's compiled table shows recoveries 41.6 per cent., and deaths 58.3 per cent.; and in Italy, where it has been done thirty-eight times, the deaths were twenty-four, or 63 per cent., and the recoveries fourteen, or 37 per cent. Experience and observation up to the present time incline me to think that the extraperitoneal method of treating the stump will be found to be the best, more frequently than the intraperitoneal."—*British Med. Journal*.

#### Eye Diseases and Leucorrhœa.

Dr. M. P. GREENSWORD, (*Med. Summary*): The longer I live the more I become convinced that there are but few physicians who have for their motto the one adopted by the Earl of Shaftesbury—"Thorough."

Since the hypodermic use of medicines in various ways, I have become thoroughly convinced that all medicines that effect cures when used either on or under the surface of the skin may be employed, with good effect, too, internally—if given in appropriate doses.

Goitres are cured by a residence on the sea coast, very often, better than by the local use of iodine. The iodine in the sea air inhaled, no doubt, becomes absorbed and thus penetrates not only the goitre but all other parts of the body.

I asked myself this question ten years ago, "Does not the nitrate of silver cure opacity of the cornea and other eye diseases, when locally applied, by becoming absorbed in the system and acting internally, as well as externally, upon the small blood vessels and absorb-

ents?" I answered this question by actual experiment.

First, I took a patient that had been blind five years, from opacity of the cornea, and gave him the nitrate of silver in doses as follows: Five grains of nitrate of silver to two of tannin and six ounces of rain water. Dose—a teaspoonful fifteen minutes before each meal. No eye water was used.

In ten days he began to receive sight and in one year his sight was nearly perfect.

After this I took a man aged eighty-two, and blind nineteen years from opacity of the cornea. I gave him the same remedy, in the same way, and in six months his sight was nearly perfect. I have since cured a great many cases of blindness from opacity of the cornea by the same remedy. It is far superior to mercury in any shape. Another advantage in using this remedy is that the patient continues to grow better for one year after discontinuing its use, if he lets all other medicines alone during that time. It seems that the nitrate of silver, like mercury, remains in the system a long time.

In connection with this subject, I would remark that I am sorry that I failed to cure some cases of opacity of the cornea, and epiphora because the patients were affected with leucorrhœa and the pus was carried from the vulva to the eyes and kept up a constant irritation. Now whenever I treat a case of eye disease in a woman affected with leucorrhœa I use locally a solution of the sulphate of cadmium for the leucorrhœa as well as for an eye wash. In the former disease, if there are ulcers on the os uteri, I make the solution of cadmium very strong, and in all cases I apply it by saturating a sponge in a solution of that remedy and pass it up to the os uteri and allow it to remain there

twenty-four hours and alternate it with sponge pessaries, saturated with pure glycerine, letting them also remain near the os uteri for twenty-four hours. Since I have adopted this rule I have been always successful in treating eye diseases when complicated with leucorrhœa.

[The oculists must settle the question of the value of the internal use of nitrate of silver in the treatment of opacity of the cornea. All gynecologists will agree that it is good for a patient to be cured of leucorrhœa, whether she also has disease of the eyes or not.] A. J. C. S.

#### Peri-Uterine Cellulitis with Abscess Pointing in Middle Line.

Dr. FRANK W. THOMAS, of Marion, O., sends us the history of a case of a woman aged thirty-seven, who at her sixth confinement was delivered of a dead fœtus sixteen days after the first beginning of labor pains. Three weeks later the patient was attacked with phlegmasia alba dolens; this disappeared in about four weeks, and then there developed symptoms of a pelvic cellulitis, the whole abdominal surface becoming hardened. For three months the patient suffered greatly from pain in the lumbar region and pelvic organs; morphine was resorted to and used continuously for months. The patient suffered from the chronic cellulitis for over a year. In about the fifteenth month the abscess pointed at a place about midway between the pubes and umbilicus. It was opened and two quarts of pus escaped. The patient then rapidly recovered. Our correspondent, who treated the case in the last months, very pertinently asks whether pointing could have been brought about sooner.—*Med. Record*.

[A case of this kind was seen in con-

sultation with Dr. W. Wallace, of Brooklyn, N. Y. The cellulitis was caused by hæmatocele. The abscess discharged at about the same point as in the case described. A probe could be passed from the opening in the abdominal wall down into the pelvis, and could be felt through the vagina.] A. J. C. S.

#### Relation Between Certain Eye Diseases and Affections of the Female Generative Organs.

The frequent occurrence of diseases of the eye during the progress of various disorders of the female generative apparatus has been noted by Dr. REM-POLDI (*Journal de Médecine de Paris*.) Among the menstrual disorders which may be accompanied by conjunctivitis, simple or phlyctenular keratitis and iritis, the author mentions especially amenorrhœa. But suppression of the menses from various causes may also be attended by affections of the choroid, by optic neuritis, retinitis, and glaucoma. In the course of inflammatory diseases of the sexual organs are frequently observed iritis and scleritis with trigeminal neuralgia. During pregnancy and lactation, Dr. Rem-poldi has observed conjunctivitis and pannus. Among the diseases appearing toward the cessation of lactation, are noted corneal ulcerations, retinal hyperæsthesia, disturbances of accommodation, photophobia, and retinitis. The author includes hysteria in the list of sexual disorders, and mentions asthenopia with retinal hyperæsthesia, and ptosis with retinal anæsthesia, as having been observed at different times in hysterical subjects. Finally, he notices the ocular disturbances dependent upon the albuminuria of pregnancy, and amblyopia consecutive to uterine hemorrhages.

**Endometritis.**

Dr. GOODELL's favorite local applications for endometritis and other similar affections of the uterus are: 1. A mixture of one ounce each of iodine, chloral, and carbolic acid. 2. One dram of pure carbolic acid to one ounce of glycerine. 3. A saturated compound tincture of iodine. 4. A solution of nitrate of silver of one dram to the ounce.

[Iodine and carbolic acid are very useful in endometritis we find. The addition of chloral is probably useless owing to the facility with which it is decomposed and rendered inert.]

A. J. C. S.

**The Fundamental Nervous Plexus of the Uterus.**

M. REIN, of St. Petersburg (*Bulletin de la Société de Biologie*) states that he has specially studied the fundamental plexus of the uterus, because, both physiologically and clinically, an exact knowledge of this network is of great importance. His description of the plexus is as follows: 1. The general features of the fundamental plexus of the uterus do not differ from those of other organs composed of non-striated muscles. 2. It is extra-uterine, and is situated principally in the cellular tissue which surrounds the vagina, just where the hypogastric plexus anastomoses with the branches of the sacral nerve. 3. This plexus presents a large number of ganglion-cells. In the plexus of the guinea-pig these cells constitute more than a hundred ganglia of different dimensions. 4. The ganglia are generally situated on the track of the principal efferent and afferent nerve bundles of the plexus. There are a certain number of small ganglia also scattered about in the network of the plexus. 5. The hypogastric, sacral, uterine, and vesical ganglia, and also those of the funda-

mental plexus, can be recognized according to the position they occupy. 6. The uterine ganglionic cells of the guinea-pig and the rabbit are limited above by the horns of the uterus. Inferiorly, the fundamental uterine plexus mixes with the vaginal plexus. None of the fibres, either of the pneumogastric or of the sacral nerves, pass into the uterus until they have mixed with those of the fundamental plexus.

**To Accelerate Involution of the Uterus.**

R. Ext. ergot fl. (Squibbs), tr. nucis vomicæ, tr. ferri chlorid., tr. cinnamon cort., aa  $\frac{\text{ss}}$  j. M.

Sig.—A teaspoonful in a wine glass of sugar and water four times a day.—*Med. Summary.*

**DISEASES OF CHILDREN.****Colic in Children.**

The *Medical Times and Gazette* says: In a clinical lecture delivered by Prof. WIDERHOFER, and reported in the *Allg. Wein. Med. Zeitung*, No. 22, we find the following observations:

By the term colic we understand an intestinal neurosis originating in irritation of a chemical or mechanical kind, of the sensory nerves of the mucous membrane of the intestinal canal. The causes of this irritation arise either in a changed condition of the mucous membrane or in the nature of the contents of the canal. There may also occur purely nervous colic, wherein neither irritating ingesta nor a pathological state of the canal is present, excitement of the central organs being propagated to the nerves of the canal. In infants who are at the breast it is indigestible milk, and especially when this is too rich in fatty matters, that causes the colic; and when children during the first six months are

fed with amylaceous food, before a sufficiency of saliva is secreted, colic is also produced. This occurs, too, when indigestible matters are swallowed, such as sand, small pebbles, etc.; and we have good opportunities of observing the operation of this cause in idiots, who often swallow such objects in great numbers. And here we have to meet the question, whether during the period of lactation the mental emotions of the nurse may not induce colic in the infant. It is beyond doubt that frequent mental emotions may induce colic with convulsions, which may be explained by the changes that are induced in the secretion of the milk.

In the group of colics induced by irritation caused by the contents of the canal, must be included that caused by constipation, by worms, and by the presence of foreign bodies. Of the morbid conditions of the mucous membrane which give rise to colic, enteritis folliculosa may be especially mentioned, and then scrofulous and catarrhal ulcers, the worst forms being observed in intussusception. Pure nervous colic appears in diseases of the spinal cord, and it may appear in hysterical form, which is not so very rare, and also as intermittent colic, with as regular rhythm as in intermittent fever. We may also include metallic colic, which certainly occurs far more frequently in children than it is diagnosed, as might be expected from the frequency with which toys are made of or contain lead.

As regards diagnosis, the purely windy colic produced by the collection of gases which distend the canal and irritate the sensory nerves, comes on with attacks of pain and with distention of the abdomen, ending with the expulsion of flatus. These attacks are paroxysmal, and are frequently accompanied by clonic con-

vulsions, which may last for some minutes, and even for an hour or more. After the cessation of the paroxysm the child is either itself again, or may remain dull and feeble. In the intervals of the attacks there are no essential cerebral symptoms perceptible. The prognosis depends upon the nature of the cause, but it has been questioned whether a colic of itself alone may not prove fatal. Through the long duration of the accompanying convulsions, through the shock and exhaustion of the nervous system, death may follow, and at the post-mortem no anatomical cause of the fatal termination can be shown. Hysterical attacks of colic especially concern very excitable children, usually nervous girls, and are characterized by violent pains, a drawn-in abdomen, slight convulsions, and obstinate constipation. In the treatment of colic we must first endeavor to remove the cause. In suckling infants, colic is especially apt to occur when the nurse's milk exhibits a large proportion of fat, and in such a case the nurse should be changed. In flatulent colic, oleum chamomillæ or fœniculi may be given, with a drop of tincture of opium as an oleo-saccharate. In metallic and in hysterical colic, belladonna is the best means; and intermittent colic should be treated by quinine.

#### **Stomach Tube in Children's Convulsions.**

Dr. WM. A. BYRD, of Quincy, Ill., supposing that most convulsions in children are due to their eating too much or partaking of improper food, thought of the stomach pump as the natural means of relief—when impossible to give an emetic. The doctor always carries with him (a first-rate suggestion, too) a common soft-rubber tube, a third of an inch in diameter, to use as tourniquet, stomach tube or anything else that it could

be used for. In a short while after determining on the use of this plan of treatment, a boy, age six years, was taken with convulsions, and the doctor found him in profound coma, eyes half open and turned back, froth from mouth, jaws tightly clenched, head thrown back, breath "sour," face purple, breathing slow and stertorous. The tube which the doctor usually carries, mentioned above, was passed with difficulty into the stomach. The stomach was first filled with warm water by means of an ordinary enema syringe, using the tube introduced into the stomach as a medium. The syphon principle was adopted in filling the stomach. By lowering the basin in which the outer end of the syphon was introduced, the stomach was emptied. Several repetitions of this procedure made the patient vomit a mass of apple peelings, as much as the size of the doctor's fist. He then injected a ro-grain solution of potassium bromide, with a few drops of laudanum, through the stomach tube. After withdrawing the tube, the boy went to sleep, and awoke in the morning all right. In another case, a large quantity of pop-corn was similarly dislodged, which was the cause of the convulsions.

Another case—girl, with severe spasms, By same method, oleander-seed were brought up. Remedies had to be used through the stomach tube for two days. She recovered in a week—the delay being possibly due to oleander poisoning. Where there is much sourness of the stomach, a solution of soda bicarbonate, with which to wash out the stomach, and then a drink of water, then sedatives should be used and the stomach tube withdrawn. The insertion of the tube is easy. Let the tubing be more than two feet long, and have a syringe that will fill the tube. If without syringe, immerse the tube in water until

it is full, and double the external end on itself, and pass through a ring, or let it be so tied as to hold it in a kink. The other end can then be easily held per orem in the stomach. This method was suggested by the late Dr. John T. Hodggen, years ago, in cases of poisoning, and most of the cases of convulsions in children are, in reality, cases of poisoning.—*Virginia Medical Monthly*.

#### Articular Rheumatism in Children.

Dr. CARL VOHSEN, (*Deut. Med. Zeit.*)

The acute articular rheumatism of children differ from that of the grown, in being of shorter duration, lasting mostly from ten to fourteen days, and in being more often complicated by chorea and heart disease.

Heart affection complicates nearly every fourth case, the severest cases of heart affection being generally associated with lightest forms of articular rheumatism.

From the report of the Strasburg Children's Clinic, nearly half the cases of articular rheumatism were complicated with endocarditis, developing usually from the first to the second week. The mitral valve and pericardium are the parts most affected.

The salicylate of soda, which has a beneficial effect upon the rheumatism, does not influence the heart affection. The author believes the frequent heart complications the result of the less resisting power of that organ in children, and the anatomical relation existing between the serous membranes, especially those of the joints and the endocardium.—*Obstet. Gazette*.

#### Subnitrate of Bismuth for Cancrum Oris.

Dr. C. J. MCGUIRE, of New York (*Medical Gazette*), claims specific action for the local application of subnitrate of bismuth for cancrum oris.

Nineteen children were attacked with the disease. Dissatisfied with the results of his treatment in the first four cases, he determined to try the effects of subnitrate of bismuth applied externally to the affected parts. The result was the immediate improvement in the appearance of the ulcers, and eventually a complete cure. From the first appearance of the disease in the institution up to the present time twenty-four cases were treated, including the four that proved fatal; out of twenty cases treated with subnitrate of bismuth only one resulted fatally.—*Med. and Surg. Reporter.*

#### **Tuberculosis of the Heart in Children.**

The following case is narrated in the *Louisville Medical News*: "A girl, eight and a half years of age, was admitted to the Children's Hospital, suffering from a remittant type of fever. The heart's action was tumultuous, with diffuse impulse; the heart sounds were distinct, but somewhat dull. The area of precordial dullness was not increased; a rather obscure friction sound was heard over the cardiac region; the pulse was quick and small. The duration of the disease was fourteen days. On post-mortem examination miliary tubercles were found in the lungs. The bronchial glands were enlarged and in a state of caseous degeneration. The heart was of normal size, and the pericardium contained about two tablespoonfuls of lemon-colored fluid. Miliary tubercles were scattered singly over the heart's surface. Upon opening the left ventricle it was found to contain a tumor five centimetres long and three centimetres broad. It was covered by endocardium, had an uneven surface, and emerged from the junction of the anterior wall with the interventricular sep-

tum, so that the greater portion of the tumor projected into the ventricular cavity. A microscopic investigation confirmed the opinion that it was of tubercular nature."

Professor Hirschsprung also reports a somewhat similar case of a girl, aged eight years, who was a healthy looking child, but on admission to the hospital had serious symptoms pointing to the cardiac region, and represented by a tumultuous action of the heart, diffuse pulsation, increased cardiac dullness, slight cough, heightened temperature, and increased respiration. Dyspnoea and cyanosis set in, and the child died seven days after entering the hospital. A tubercle as large as a walnut was found in the internal wall of the left ventricle; a few miliary tubercles in the anterior part of the left upper lobe, and nowhere else in the lung; the bronchial glands, especially on the left side, were found in a state of cheesy degeneration, as were also the mesenteric glands; there were tubercles in the spleen and pericardium. The liver and spleen were enlarged, and the intestinal glands swollen, but not ulcerated.—*Jahrbuch für Kinderheilkunde.*—*Med. Record.*

#### **Nocturnal Incontinence of Children.**

This trouble is annoying and often intractable. Professor S. D. GROSS (*Mich. Med. News*) advises the use of the following formula: Strychnia, gr. one; pulv. canthar, gr. two; morphia sulph, gr. one and a half; ferri pulv., gr. twenty. He directs the pill mass to be divided into forty or fifty pills, according to circumstances. Under the use of this formula, together with careful hygiene, almost all cases of nocturnal incontinence in children rapidly improve.—*Chic. Med. Review.*

**OBSTETRICS.****An Unusual Relation Between the Placenta and the Membranes.**

In the September number of the *New York Medical Journal and Obstetrical Review*, Dr. HENRY J. GARRIGUES, of New York, describes a very remarkable relation between the membranes and the placenta. "The placenta measured twenty centimetres in diameter, the cord sixty-four centimetres in length, and both were of nominal thickness. The cord was inserted centrally. The membranes which had contained the child did not adhere to the edge of the placenta, but started from the point of insertion of the cord on this organ. Measured in a flaccid condition, hanging down around the cord, this bag was forty-one centimetres long. It was easily separated into two layers. The inner layer was covered with the epithelium characteristic of the amnion, a single layer of flat polygonal cells, which were in a state of fatty degeneration, as proved by numerous oil-globules found in their interior. The outer layer consisted only of connective tissue, which, in some places, contained a few round or oval cells, and many fat-drops. In other places some loose shreds were found on the outer surface, which showed a greater number of similar cells. At the placental end of the cord the sac was seen to form a kind of triangular mesentery, embracing the first eleven centimetres of the cord, and attached to the sac to a similar extent. The two layers forming this fold were not united, so that the finger could be pushed in between them up to the cord; but at the lower end (*i. e.*, nearer to the fœtus) they grew together, so that a pouch was formed between the "mesentery" and the cord, admitting half the

length of the index. At the placental end of the cord there was found in the interior a small clear vesicle of the size of a pea (the umbilical vesicle). The placenta presented a common, shining, smooth fœtal surface, and rough maternal surface. The edge looked ragged, as if something had been torn from it, and in one place even a small, square piece of membrane about two centimetres in either direction was found attached to it. This membrane had no epithelium, and was composed of an inner layer of connective tissue, and an outer layer containing many round and oval cells. From the fœtal surface two membranous layers could be dissected off. The most superficial was exceedingly thin, the deeper one comparatively thick, and bound by isolated fibres to the placental tissue. The fœtal surface had no epithelium.

The chief point of interest was that the sac in which the fœtus was placed, and which contained the amniotic fluid, was not attached to the circumference of the placenta, but to its centre, all around the insertion of the cord. Microscopical examination showed that this sac was composed of the amnion and the chorion, but had only scant remnants of decidua attached to it here and there. On the other hand, the portion of membranes found attached to the edge of the placenta was composed of decidua and chorion without amnion, and the fœtal surface of the placenta had no amniotic epithelium. Dr. Garrigues supposes, therefore, that the placenta all around was separated, after the birth of the child, from the decidua, which remained attached to the interior of the womb. Secondly, that the amnion and the chorion together formed a fold from the circumference to the centre of the placenta, which fold on one side was open, and formed the meso-

cord described. Such a folding was perhaps brought about by accumulation of fluid between the chorion and the decidua after the formation of the placenta. At first he supposed that the amnion alone partook of the folding; but then we should find, he adds, on the sac surrounding the fœtus, the line where the chorion had been torn, and there was no trace of anything of the kind. He thinks, therefore, we must conclude that the chorion remained close to the amnion all the way, and was folded with it so as to cover the fœtal surface of the placenta twice, as well as the amnion. This supposition is corroborated by the fact that two layers could be dissected from the fœtal surface of the placenta. The outer one was very thin, and this he took to be the chorion; the inner was thick; and this he explains as being the two layers of amnion grown together by their epithelial surfaces.

#### Placenta Prævia.

Dr. SPENCER T. SMITH (*British Med. Jour.*) relates a case of placenta prævia where the placenta was found to have been expelled into the vagina. The child was found lying transversely across the uterine cavity. The placenta was removed and the child extracted without trouble. There was no hemorrhage. This case is somewhat singular from the fact that, although there was complete placenta prævia, as already mentioned, there was no hemorrhage. The placenta probably was expelled from the uterus early in labor and acted as a tampon.

[Retraction of the uterine muscular structure over the placental site and pressure of the presenting part of the fœtus, after expulsion of the placenta, is a more rational explanation of the arrest of the hemorrhage. A parallel case occurred a few months ago to

the writer of this note. The entire placenta was found in the bed still connected by the cord to the fœtus in utero. The expulsion of the placenta had occurred five hours before my arrival and and yet there had been no hemorrhage.]

J.

#### The Management of the Placenta After Abortion.

Dr. H. V. SWERINGEN, in a communication to the *Cincinnati Lancet and Clinic*, protests against meddling midwifery, and especially against the absurd teachings of some authorities, with regard to the management of the secundines, which he regards as less likely to produce blood poisoning if retained for a few hours, than it is now fashionable to believe. He reports cases showing that operative interference is more likely to produce injury and septicæmia, than leaving the patient to nature and a good nurse. After insisting upon drainage and hot water injections, he inquires:

May it not be true that something more is necessary to cause blood poisoning than the mere absorption of decomposed placenta; that there is such a thing as benign, non-infectious, innocent or harmless putridity in the same sense that we speak of healthy or laudable pus? Robin asserts that putrefaction destroys animal poisons, and this view is sustained by a number of cases in my practice, treated since the notable one of Mrs. Ryan's, in which the odor was most intolerable, unusually disgusting, more characteristically putrescent, and yet they all recovered their normal condition without the slightest symptom of blood poisoning. This happy result may, however, be wholly due to the fact that no part of the foul drainage had been taken up by the circulation; but it is worthy of note, that in the fatal

cases of child-bed fever which I have seen the fetor present was not to be compared in offensiveness with that which characterized the cases of recovery from retained placenta. I have read somewhere an account of several cases in which the entire placenta were absorbed without producing any deleterious results whatever; but in these instances they may have remained so vascular or so vitally connected with the uterus that they were simply removed as an ordinary deposit of lymph is absorbed, without the occurrence of the least amount of decomposition.—*Coll. and Clin. Record.*

[This is a step backward; we fear Dr. S. will find refutation of his doctrine in a few years' clinical trial.] J.

#### **Tolerance by the Uterus of Traumatic and Septic Influences.**

Dr. VALENTA relates a case in which the head of a full-term child, together with the placenta, was retained in the cavity of the uterus for six weeks. The child presented by the shoulder, and after version was delivered as far as the head. The latter resisting all efforts made to extract it, the medical attendant simply cut it off and went his way. After numerous attempts to remove it, the head was finally extracted piecemeal after remaining in the uterus for forty days. During this whole period there was no signs of reaction, the pulse and temperature remaining normal.—*Schmidt's Jahrbücher.—Med. Record.*

#### **Carbolic Acid Injections in Puerperal Septicæmia.**

In the *N. Y. Medical Journal*, Dr. POLK, of the Medical Department of the University of the City of New York, reports a case of puerperal septicæmia

in which hypodermic injections of a two and a half per cent. solution of carbolic acid were followed with excellent results. The solution was warmed to 100° F. and injected every four hours. The temperature was almost immediately reduced when it was used, and went up again when its use was discontinued for a very short time. The urine was examined as a precautionary measure to determine the amount of sulphates present, and this was repeated from time to time, as it is maintained that absence of the sulphates is the first sign of carbolic acid poisoning. The urine was tested as follows: A drop or two of nitric acid was first added to dissolve the phosphates, if present; then a solution of barium chloride, the reaction causing a white precipitate of barium sulphate. This plan of treatment is worthy of a more extended trial.

#### **Butternut as a Preventive Remedy in Abortion.**

Dr. BELL MORRELTON reports (*France Médicale*) several cases in which the extract of butternut (*juglans cinerea*) seemed really efficacious in preventing abortion.

He employs the following mixture:

R. Ext. hyoscyam., ʒ j; ext. juglans cinerea, ʒ j.; ol. sassafras, ʒ ss.; sodæ bicarb., ʒ ss.; syr. simplicis, ʒ vj. M.

A teaspoonful of this mixture may be administered three times daily during the entire period of pregnancy, after the threatened abortion.

The same physician has also employed this remedy in scrofulous affections and as an injection in leucorrhœa.

## DISEASES OF WOMEN.

**Anteflexion of the Cervix Uteri, with Stenosis, Treated by Rapid Dilatation.**

The *Medical Times* contains a lecture by WILLIAM GOODELL, in which he gives the following treatment for anteflexion of the uterus :

I shall treat this case by rapid dilatation, which I consider the best treatment under these circumstances. I have never had a fatal result after this operation. I, in one case, had quite a severe attack of peritonitis in a patient who went home on the same day that I operated. I have been obliged to keep two or three patients in bed for a week, but I have never had such a degree of fever as to cause me any anxiety. This cannot be said of the cutting operation, which is not unfrequently followed by death.

Catching hold of the cervix, I pass in the dilator (Ellenger's) in the same way that I did the sound. The obstruction does not appear to be due so much to the smallness of the canal as to the bend in it, for the dilator readily passes through it. You observe that the instrument has a shoulder at a little over two inches from its tip. This prevents the end from reaching the fundus of the womb, for if it did the womb might be torn when the blades were separated. I now gradually dilate the os, but, although the blades are parallel, the wound seems to recede from the instrument, allowing it to come out. Having stretched the canal to as great an extent as is possible with this instrument, I substitute my own dilator, which is much more powerful. I bring the handles together, take away the ether, and allow the instrument to remain until the woman begins to squirm. I then remove the instrument.

Formerly it was the custom, when ether had been given, to try to arouse

the patient by striking the face with a wet towel, calling loudly, giving a glass of brandy, or by some other means, as soon as the operation was finished ; but my rule is to allow the patient to sleep as long as she will. She is then not so drunk, the pain and soreness of the operation are gone, and she is not so likely to be nauseated.

In these cases of dilatation of the cervix, I order six one-grain suppositories of the aqueous extract of opium. I introduce one just before the operation, so that it may have dissolved by the time she recovers from the ether, and order the nurse to give one every two hours until the pain is relieved. This may require three or four. It is rarely necessary to use the six.

Are there any accidents from this operation? I think that in two of my cases the internal os must have been ruptured, for there was a sudden giving way, and I could bring the handles of the dilator together without meeting with any resistance. The first time this occurred it worried me a good deal ; but no bad symptoms followed. The second case behaved in the same way. Still, I do not like such accidents, and I now perform the operation somewhat more slowly than formerly. I have met with another accident in a case which had been treated by nitrate of silver. Ten years ago, almost every woman who had any sort of uterine trouble, had a stick of nitrate of silver passed into the canal : as a result, the os was in many cases almost and in some entirely obliterated. In treating a case of that kind some two years ago, the dilator slipped out, tearing quite an opening through the external os, but that did not amount to much. There was pretty free hæmorrhage, which was checked by Monsel's solution. On another occasion, in a virgin with a small os, the instrument slipped

out, tearing the os. These are the only accidents that I have met with. This makes my one hundred and thirtieth or thirty-first case of which I have the record, and there are other cases of which I have kept no account. This operation is looked upon with disfavor by many, and the dispute in regard to the advisability of performing this or the cutting operation led me to keep a record of my cases. Many hundreds of women have had the cervix cut, and many have died. I lost a patient by the cutting operation four or five years ago. I have cut the cervix only once since, and the result was not so satisfactory as it is after dilatation.

I now remove the dilator, and you see that the internal os has been stretched at least an inch. Of course that amount of dilatation is not going to remain; but I have overstretched the canal, and it will not return to its former size. It is sometimes necessary to perform the operation a second time; but the woman is usually so much benefited by the first that she readily submits to the second.

She will now be put to bed, and the suppositories used in the way I have described. Opium suppositories have three great advantages: 1, they cannot be vomited; 2, you bring the drug near the point of suffering; a grain of opium by the rectum in these cases will do more good than a hypodermic injection of a larger dose; 3, they cause less nausea than opium in any form by the mouth.

Let me here allude to another practical point. You know that belladonna is often given with opium, and it is a good combination under some circumstances; but it is not good where you have to push the opium. You can give, where there is much pain, six one-grain suppositories of opium, but if belladonna is combined with the opium, the patient will be poisoned by the time the second

or third has been given, and, as you know, the symptoms of belladonna-poisoning are very alarming.

#### **Treatment of Vaginal Prolapse.**

Clinic of Prof. BREISKY: We find in this patient a complete prolapse of the vagina. On further examination a small round tumor may be felt, situated high in the abdomen, and sufficiently mobile to allow its being pushed into the region of the right hypochondrium.

We may have either an ovarian tumor with an extraordinarily long pedicle, or a growth originating higher up in the kidney, which in this case would be swollen, fluctuating and changed in form. In order to prove that it comes from the kidney, we must be sure of no connection between it and the genitalia. It will then have no cord-like union between itself, the uterus or its appendages, and the ovaries will be found by rectal palpation to be in place. Even if we fail to discover this connection, the tumor may be a cystic outgrowth from the parovarium, although they are generally interligamentous. Schroder has mentioned observing cystic tumors with both ovaries intact. We must also consider whether the ovary may not be double upon one side, as described by Klebs and others, in which case one may have undergone cystic degeneration. It would then remain to be determined whether the tumor had a distinct pedicle-like union with the uterine appendage of one side, if it followed the movements of the uterus, or if it participated in them. Long pedicles are rare with small tumors, occasionally dermoid cysts are furnished with them, when a diagnosis of wandering kidney is often given. Rectal examination is difficult, because of its fulness and a stenosis resulting from former ulcerative process. Still the cord-like connection

between the tumor and the genitalia may be felt. It gives her no trouble and may not for years. She seeks relief from the prolapse only.

The second patient is a thirty-eight year old primipara, who, after a difficult labor, shows a tumor about the size of my fist, which goes back when she is lying and becomes smaller after defecation. In the upper part of the right labium is a furuncle. The inner surface of the great and small labia to the clitoris are of a bluish gray color; the skin is glistening, dry, withered and relaxed because its glands secrete neither oil nor moisture. There is also an xerosis of the vestibular region. This is in rare cases the point of origin of changes which may lead to atrophy and stenosis, to a perfect disappearance of the great and small labia, and to a perfect loss of the frenulum and præputium clitoridis, to stenosis of the vulva. The dry and brittle tissues tear easily, cohabitation becomes painful and mechanically difficult through shrinkage of the dry parts. Clinically these forms of dryness are to be distinguished from those left by chronic eczema in elderly persons. The uterus is low, the cervix directed forwards, the os wide, relaxed and deeply lacerated, the parts not ectopic, but hanging down, tongue-like, making the cervix appear thicker. The uterine body inclines to the left, the left ovary may be felt slightly enlarged and having on one side a spindle-shaped swelling the size of a date. The middle part of the vagina is folded, and, judging from appearances, we have a cystocele to deal with, the tumor disappearing on emptying the bladder. The fold in the vagina corresponds to that in the bladder, otherwise must the vaginal fold be solid hypertrophy, which condition is found when the prolapse remains without the vulva. In this case the fold is neither

toughened nor thickened and its surfaces have not the character of epidermis. Probably the urethra has bulged into the vesico-vaginal septum, which the catheter has proved to be the case. We have then prolapsus vaginæ anterior, cystocele, depression and deviation of the uterus, hypertrophy of the portis vaginalis, and slight enlargement of the left ovary. The prolapse must be replaced. The measures for its retention may be palliative or radical. The latter to be preferred, especially with the working class. Many operative procedures have been tried and failed. Dieffenbach's method is not now used. Baker-Brown and other's operations has been modified by Frinke, but, in common, they narrow the vulva and lengthen the perineum. The results were bad. Later the operation was again taken up by Simon and Hegar in Germany and Lewis in America. Bischoff has a modification of his own. These operations may be combined in any case according to its needs. If the vaginal tissues are hypertrophied, there is a strong pressure and disturbance of the circulation after reposition. Just so when the uterine lips are hypertrophied, the weight of the organ is increased, as well as its tendency to press down, then the hypertrophied tissues should be removed, the cervix amputated and the hypertrophied fold removed by excision. This auxiliary operation is used for the relief of cystocele and prolapsus colli. Huguier's method of removing the supra-vaginal part is useful in cases of elongation. Neussbauer and Le Fort propose to unite the posterior and anterior vaginal walls. This prevents vaginal inversion and decreases the prolapse. Such a vagina would offer an impediment to cohabitation and childbirth. In elderly persons where these things may be left

out it promises well. We will use it in our first case, as she has been operated on three times unsuccessfully.

The second case will be treated by excision of the posterior vaginal wall, with Emmet's operation for the cervix. —*Obstet. Gazette.*

#### Dilatation of the Uterus.

To dilate the uterus for diagnostic or therapeutic purposes Prof. SCHULTZE uses a tannin-glycerine tampon, then his own laminaria tent, after which he washes out the cavity daily with from one to two liters of carbolyzed water. In catarrh and endometritis, without complications, good results are speedily obtained, and no unpleasant accidents need be apprehended. If endometritis is not benefited, the uterus is dilated and any growths (granulation adenoma) are removed. The opening of the Fallopian tubes and boundaries of the fundus are favorite localities for little adenoma, that are often brushed over with the curette without removal unless the organ is well dilated. —*Ibid.*

#### Menstruation and its Derangements.

ALFRED MEADOWS, M.D., F.R.C.P. (*Can. Med. Record*). Amenorrhœa must be carefully distinguished from *delayed Menstruation*, since, though in the latter class of cases the menstrual discharge may not appear for many years, even after its usual time, yet it is a distinct condition, as will be seen later, from that of which absolute absence of all discharge at all times is the sign. The discharge usually appears for the first time at about 14½ years, but is subject in this respect to almost infinite variety. In rare cases it is *never* established, and they call for particular and separate study. The diagnosis of amenorrhœa, however, is a comparatively easy matter. As its name implies, the presence of the condition is

at once established by simple observation. The *cause* is another matter, and must be looked for in the condition of the organs implicated. Thus a mechanical obstacle may prevent the outlet of the discharge, in which case its progressive increase quickly reveals the true state of the case, for in every instance of true menstruation *ovulation* is an invariable accompaniment, it is as invariably absent in every case of true amenorrhœa. Some inexplicable cases, however, must be admitted to occur; but in every instance of congenital defect, the subsequent unusual symptoms will be found due to the arrested development of the genital apparatus. Either the ovaries will have been arrested in growth, or the ovaries and uterus may both have shared in it; but, as a rule, there is a less degree of malformation than this, an imperfect kind of menstruation, small in amount, being possible to the organs. These cases admit of early recognition, and in them the ovaries can be proved to be the organs at fault. There are other cases in which the menstrual function, after being duly performed, perhaps for a considerable number of years, may become arrested and entirely cease, as a consequence of some local and general and constitutional changes, the essence of which, Dr. Meadows' experience tends to demonstrate, is a blood poisoning of some description. Thus after blood poisoning due to scarlet fever, arrest of the menstrea is by no means uncommon; and similarly, though less frequently, the same effect may be produced after measles, typhoid fever, and rheumatic fever. In all such instances, the pathology is obscure, but the changes are probably due to *atrophy* of the ovary, and no hope of effectually remedying the condition can be entertained. Colds taken during menstruation are another cause of arrested function. Pain is a

frequent accompaniment of these cases in which inflammation being induced by the exposure, trophic changes follow, producing a state of things for which it is futile to expect a remedy to be found.

The *cause* of all the menstrual irregularities above described is arrest of *ovulation*; the ovary atrophies, shrivels, shrinks up, becomes mobile in the pelvis, but usually out of reach, and assumes a senile appearance. Diagnosis is confirmed by cessation of function, and the clinical history forms an explanation of the cause of the change.

Treatment of amenorrhœa, under whatever form, resolves itself into treatment of ovarian atrophy; and hence the indication first and foremost is, to stimulate the sluggish action of the organ. Very few remedies, however, can be relied on to effect this result—if, indeed, any—and when the condition is consequent on blood poisoning, absolutely *nothing* will avail to produce any benefit. Tincture of cantharides, in ten to twenty minim doses, have been most efficacious in Dr. Meadows' hands, where remedies have not been resorted to in vain; and rue and savin have a reputation in the same connection. Iron will be of service when the constitutional state demands it, and blisters may be productive of some slight good. The most efficient agent, however, in any case of the kind, is undoubtedly *electricity*, and the method of applying it as a stimulant to ovarian activity has occupied the attention of several authorities. The late Sir James Simpson advocated the use of an intra-uterine galvanic stem, by the employment of which the uterus is excited, lumbar pains are produced, and a slight discharge is provoked. This is certainly not a true menstrual discharge, since it possesses no ovarian character, and is not preceded by the excitement of ovarian activity to ovulation. Moreover,

this mode of applying electricity is attended with serious risks, it being within Dr. Meadows' experience that it may be followed by retro-cellulitis and pelvic abscess, the stem in one case referred to having been removed with difficulty, and found to be covered with a thick membranous deposit from the irritated mucous membrane adjacent. Stimulation by galvanism for a short time daily has been adopted with better results, special bougies, sounds, etc., having been constructed to facilitate the passage of electrical currents to particular regions as required. Daily passage of sounds, introduction of sponge tents, and dry-cupping, are other modes of promoting functional activity which are unscientific and extremely unsafe proceedings. By these means irritation of a kind is certainly set up, and a thin sanguineous discharge is provoked, but this is by no means *menstruation*, for, in the circumstances, the ovaries are not in the least degree affected, and without they are in active function, ovulation and true menstruation cannot take place. It is nevertheless possible to transmit the electric current directly through the ovaries, several plans having been suggested for thus exciting them to action. The patient may be placed in a galvanic bath, or the poles of the battery may be adapted to secure the desired end in various ways. The bath is to be preferred in many cases, and in conjunction with it enemata of rue and tinct. cinnamon on alternate days, for five or six times, may be advisable.

It is well to remember that obesity is a frequent accompaniment of amenorrhœa, and even plethora, the latter being more common in married women than in single. Also, the uterus varies as the general condition of the body differs, and the general treatment must be carefully directed on well-known general

principles, in regard to such conditions.

In *chlorosis*, amenorrhœa is not, as is generally insisted, a *cause*, but a *consequence*, of the condition of the blood. To this is due the arrest of ovulation, and any attempt to restore the function must be addressed to improving the state of the blood, without any regard whatever to the generative organs pending essential changes in the circulating medium. These once brought about, menstruation will be re-established without any special attention being directed to it. The digestive system, however, should be seen to.

*Dysmenorrhœa* in some of its forms presents characters analagous to those exhibited by amenorrhœa. It may vary wonderfully, from a large amount of discharge to a mere "show." As the amount of nervous excitation produced is to be taken as a measure of the ovarian act, it is evident that when this is scanty and abortive pain will not accompany it, the effect produced, or energy displayed being too infinitesimal to bring it about. Nevertheless, as long as a discharge, however small in amount, is regular in appearance, there is good hope of restoring the functional vigor of the organ.

Scanty menstruation is commonly associated with obesity of figure, and sterility as a consequence of improper ovulation. Examination per vaginam of such cases shows that the organs generally are normal in form, etc., but that the ovaries are atrophic, and, as a rule, undiscoverable by the fingers in this position. The uterus may exhibit scarcely any alteration. In all such instances the diminution and cessation of the menstrual discharge are matters of time and degree, and are thus sharply separated from those in which total disappearance suddenly follows blood-poison-

ing. In case of gradual loss of function, emmenagogues may be found useful, but bromides and iodides are contraindicated when the signs are as above described. With them, however, electricity is signally serviceable, but must be frequently applied to secure benefit, the reason for this being that the remedy acts on a function which only recurs periodically, the ovaries and *not* the uterus being the organs implicated.

Entire *absence* of the generative organs is very rarely witnessed, only a single instance ever having come under Dr. Meadows' own observation. This was an infant which lived but a few minutes after birth: ovaries, uterus, and urinary organs were all wanting.

*Rudimentary* organs may be encountered. Thus, when the ovaries are abortively developed, menstruation will be very slight, and treatment must be directed to assisting the better development of the stunted organ. A rudimentary condition of other organs, *e. g.*, uterus, vagina, and especially the mamæ, usually goes with this condition of overy when occurring congenitally.

The ovaries may be perfectly normal in all respects, and the uterus also, above the os, but from that point occluded. In such a case diagnosis will be simple if the vagina also is normal, for a globular, bulging tumor of increasing size will be found in the situation of the cervix, which needs only not to be confounded with pregnancy. The real nature of the case being understood, a trocar may be introduced for the evacuation of the uterine cavity, care being taken to preserve the vaginal wall from contact with the confined, acrid secretions.

Lastly, dysmenorrhœa may be due to occlusion of the vagina, necessitating operative procedure for relief. Here it must be remembered that true amenorrhœa has not been present, and preca-

tions must be taken to guard against danger to the patient, by (1) evacuating the collection of fluid slowly, (2) excluding air from admission to the pent-up fluid, (3) freely injecting disinfectants into the cavity opened, and (4), by acting on the uterus with oxytocics.

[In this age, when so many are trying to divorce the functions of ovulation and menstruation, it is agreeable to find so reliable an authority as Alfred Meadows advocating their correlations. This is the most rational view of the functions of the sexual organs, and agreeing as it does with facts observed in practice, gives the key to the derangements of menstruation in many cases.]

A. J. C. S.

#### Manganese in the Treatment of Amenorrhœa.

DRS. SYDNEY RINGER and WILLIAM MURRELL call attention (*Lancet*) to the value of this simple remedy in a very common complaint. For some time they have used permanganate of potash with much success in the treatment of certain forms of amenorrhœa. Their observations extend over a period of thirteen months and they have now notes of 69 cases.

They have used the permanganate in two forms, first, the pharmaceutical solution, and secondly, the permanganate made into pills, each containing one or two grains. Generally they begin with a grain three times, and then gradually increase the dose to two grains four times a day. Their most striking results have been obtained with the larger dose; a large dose sometimes succeeding admirably after the failure of a small one. Before commencing treatment they inquire into the menstrual history of the patient, and as a rule give the remedy only for three or four days immediately preceding the expected period, but

should it fail to produce the desired effect, then direct the patient to continue steadily taking it, and in some cases it has been taken continuously for nearly three months. No other treatment was used in these observations. The most striking results were obtained in young women between eighteen and twenty-five, who from some accidental cause "missed" once or twice. The administration of one or two grains of permanganate in pill three or four times a day for a few days before the expected period will bring on the flow almost to a certainty. In some instances the periods were brought on after the patient had ceased menstruating for over a year. It is not necessary to discontinue the treatment on the appearance of the menses; in fact, they tell the patient to continue taking the pills three or four days longer, finding that it facilitates the flow. It re-establishes the menstrual function where the patient has menstruated once or twice and then ceased.

They say: "It is not only in the case of young women that manganese is so useful, it succeeds almost equally well with women between thirty-five and forty, who, as the result of many pregnancies and much suckling, have ceased to be regular."

Before treating amenorrhœa, care should be taken to see that the patient is not pregnant, although they say "the permanganate given in the dose we recommend has no power to produce abortion either in the early or late stages of pregnancy."

As a rule the permanganate is taken without difficulty. The solution is disagreeable to take, and in some cases produces nausea and even vomiting. The pills are preferable.

They say, in conclusion: "That the effects we have described are due to the manganese, and not to the potash in the

salt, is shown by the fact that manganate of soda and binoxide of manganese are equally efficacious in the treatment of amenorrhœa. The manganate of soda was given in two grain pills, two to four times a day; and the binoxide in four grain pills, one four times a day. It may be thought that the manganese acts by improving the condition of the blood, but this is not the case. The treatment succeeds equally as well in the plethoric as in the anæmic. Given in cases of chlorosis the permanganate not infrequently brings on the period without in any way improving the anæmia."

[We have tried this remedy in five cases with negative results. More observations will be made before deciding for or against the "certainty" of this action of this drug.]

A. J. C. S.

**A New Method of Exploration, with the Pathology and Treatment of Certain Lesions of the Female Urethra.**

In a letter to the *Western Medical Reporter*, Dr. D. A. K. STEEL describes a case in the practice of Dr. Thomas Addis Emmet, the treatment of which was witnessed by him.—*Coll. and Clin. Record.*

The patient (an inmate of the Woman's Hospital) had suffered for several months with symptoms of vesical irritation, pain, tenesmus, frequent micturition, etc., which symptoms, on examination, were found to be due to a hypertrophied and dilated urethra, with surrounding cellulitis. She was fully anæsthetized, and placed upon a table, on the left side, with limbs well flexed; a moderate sized Sims speculum was introduced, thoroughly exposing the vaginal mucous membrane covering the urethra, when the blunt blade of an instrument resembling a button-hole scissors was introduced into the urethra, and with a single snip a *button-hole* was

cut in the median line of the urethra, one-fourth of an inch back of the meatus, and extending nearly to the neck of the bladder. The instrument was withdrawn and the mucous membrane on the vaginal surface nicked back about one-third of an inch further. The vaginal and urethral surfaces were now united by a number of interrupted fine silk sutures, care being exercised to introduce them at the sides and meatus end of the button-hole and not at the bladder end, for fear of the danger of incontinence, which ensued in one case when a stitch had been placed in the distal angle of the slit.

The advantages claimed by Dr. Emmet for this operation were, that the entire urethral canal could be thoroughly and safely examined, accurate diagnosis of urethral diseases made possible, and medicaments applied to diseased surfaces freely and intelligently, and facility given for operative procedures. He considers it is one of the greatest advances in gynecology he has made. Dr. Emmet does not ordinarily use the urethrotome, but prefers a large block tin sound in the urethra, upon which he cuts down with an ordinary scalpel, or straight, sharp-pointed scissors. Control of urine is not impaired, and no difficulty has been experienced in closing the slit subsequently.

The operation is not in any sense intended as a substitute for artificial vesicovaginal fistula, formed for the cure of cystitis, or removal of stone, but simply to facilitate exploration, diagnosis and treatment of the urethra and its diseases, in a rational and scientific manner. It certainly opens a new field for thoughtful surgeons, and it is an operation not so likely to be abused as that for closure of real or supposed laceration of the cervix uteri.

## DISEASES OF CHILDREN.

**The Treatment of Whooping Cough**

By means of sprays has met with good success. Dr. J. J. CALDWELL again calls attention to the following:  $\mathcal{R}$  Ext. belladonnæ, fl. gtts. xij.; ammon. bromidi,  $\mathcal{O}$ i.; potass. bromidi,  $\mathcal{Z}$ iv.; aquæ distil.,  $\mathcal{Z}$ ij.

This is used as a vapor spray to be inhaled every four hours. Duration of the spray five to ten minutes, or until the pupils are dilated.

**Treatment of Whooping Cough.**

Dr. HARRIET E. PRESTON in reporting on the diseases of children says: Whooping cough has lost its terrors in the hand of the skilful practitioner, and may be limited to a very mild and brief form of coryza.

The coal-tar products, notably cresyl-line, have almost specific action in whooping cough. Of this last preparation a few drops, from two to six, vaporized by heat and breathed by the patient, gives speedy relief, is easy of application and safe; may be repeated as often as the spasm of coughing returns, but there will not be usually many such returns.

She also reports success from the use of the acetates of morphia and atropia, as in the following formula:  $\mathcal{R}$  Morphiæ acetatis, gr. j.; atropiæ acetatis, gr.  $\frac{1}{4}$ ; syr. simplicis,  $\mathcal{Z}$ i. M. Sig.: Five to thirty drops once or twice daily according to the age of the patient and the severity of the disease. — *Minnesota State Trans.*

**Der Keuchhustenpilz the Germ of Whooping Cough.**

From the *Berliner Klin. Wochensch.* we learn that Dr. BURGER has discovered in the sputa in cases of whooping-cough

certain organisms which he holds to be specific and the cause of the disease. These organisms he describes as small rod-shaped structures, varying with one another in length, though in general they are twice as long as broad. They may be found lying apart from one another, scattered over the field, or combined to form groups or chains. They appear in the sputa in large numbers, and can readily be distinguished from the other forms of bacteria that are constantly found in the mouth. According to the author, the only organisms they are likely to be confounded with are the spores of the ordinary leptothrix buccalis. No especial method of staining is necessary to render them visible. Koch's method, now so generally availed of in the preparation of the tubercle bacilli, was used, and methyl violet or fuchsin used as the staining liquid. These bacilli are different from the forms described some time ago by Letzterich in similar cases. The author regards them as the cause of the disease because they are found in no other sputa. They are so abundant that one must suppose they have some influence. Their quantity is always relative to the intensity of the disease, and finally the course and symptoms of the disease are best explained by their presence. A paper is to follow giving an account of experiments in cultivation and inoculation. It is also to be hoped that this paper will contain a better account of their size and form. — *Med. Med. Jour.*

**Treatment of Whooping Cough with Eucalyptus.**

Dr. WITTHAUER reports four cases of pertussis, treated with tincture of eucalyptus globulus, which recovered in a little over three weeks. The dose for children from two to four years of age was  $\frac{5}{8}$  drops. One of the patients, eight-

een months old, suffered from well-marked rickets. After taking the eucalyptus for four weeks, not only was the whooping cough cured, but the enlarged epiphyses were reduced, and the child, who had never before attempted to stand on its feet, learned to walk.—*Memorabilien*.

#### Treatment of Summer Diarrhœa in Children.

Dr. A. MULLER (Transactions of Lancaster County Medical Society.) Attention to diet is a very important point in the treatment of diarrhœa. In regulating the diet, we will often remove the cause of the disease, which is commonly induced by improper food, and which may often be remedied by attention to this point alone; while no medicines will be of any account if this be neglected. In the beginning of the attack, gum-water and barley-water form very good articles of food and drink. Milk had better be diluted with water, even to the extent of one-half, as in its pure state it is almost always too strong for the delicate stomach and yet more sensitive intestines. Rice forms a very good article of food, if thoroughly boiled (especially if the child is not at the breast), as it, as a matter of food, leaves very little excrementitious matter. But if the child is nursing, the mother's milk is sufficient; and by far the best diet for it, provided her health is in a good condition. Keeping the surface warm and the skin in a good condition are very important in the treatment of diarrhœa, hence the utility of warm clothing, warm baths, fermentations to the abdomen, and friction. A flannel bandage around the abdomen is often of great service, both from the warmth it imparts, and the support it gives to the viscera within. The feet should be kept

warm. Pure air and an equable temperature are also very essential.

As to medicines, the question of giving an aperient at the onset is to be considered. If the child has been fed on improper food, and we have reason to think that indigestible articles of diet are in the alimentary canal, it is proper to begin the treatment with an aperient, in the shape of castor oil, magnesia, or some one of the preparations of rhubarb. But when the infant is very young, and fed on nothing but the mother's milk, and the evacuations profuse, we must in all cases try to moderate the discharge from the bowels. This can be done by the exhibition of some of the vegetable astringents, either alone or combined with opium in properly guarded doses and antacids. A very good method of administering opium is in the form of Dover's powder, where we have the sedative effect of the opium and the diaphoretic action of the ipecacuana. Although some may object to giving opium to a very young child, we meet with cases in which the pain and tenesmus are so great that it is our sheet anchor. Mercurials are also very necessary sometimes where there is a lack of bile in the evacuations, they being white or clay-colored. The form in which I generally give it is the hyd. cum creta. When we have green and acid stools, some of the antacids are to be given in the form of lime-water, creta prep. or chalk mixture. In cases of high fever nitre may be given, in the form of nitrate of potash or spts. ether nit. When diarrhœa has long existed, the use of turpentine is occasionally of great service, especially if much flatus exists in the bowels. In cases where the head is involved, or likely to become involved, great benefit will be derived from the use of blisters on the side of the head, back of the ears or the nape of the neck. Cold in the

form of cloths wrung out of ice-water to the top and front of the head at the same time to be used.

#### **Cerebral Hyperæmia in Children.**

Dr. WM. T. PLANT (*Detroit Lancet*). Cerebral hyperæmia is itself, as you have seen, but a symptom; an expression of some antecedent morbid state. But it is of such frequency and importance in the young as to merit separate and special consideration.

The active form usually appears somewhat suddenly. Increased heat of head, headache, super-sensitiveness to loud noise and bright light, reddened eyes, contracted pupils, flushed face, throbbing carotids, bulging and pulsation of the anterior fontanelle, if it is still open; a froward temper, disturbed sleep, twitching tendons, sometimes nausea and vomiting, sometimes convulsions and coma—these are the principal symptoms.

The passive form is usually of slower development. There is less activity than in the other. The pulse is not so frequent; the skin may be pale and the face cool. The fontanelle does not pulsate and probably is not so tense as in the other form. If you reflect that in all instances in which the blood supply of the brain is increased or diminished, or perverted in its quality, the organ suffers from innutrition and malnutrition you will not be surprised to find that some symptoms are common to different and even opposite morbid states. Such is the fact. Uneasy slumber; periods of restlessness alternating with stupor; peevishness; jerking of the limbs, and headache, belong alike to anæmia and congestion, both active and passive, and to some other affections as well. But the diagnosis is readily enough made if you take all the circumstances into account.

The prognosis will depend, of course, on the cause of the congestion. If that is transient, as anger, joy, fright, fatigue or some trivial thing that quickens the circulation but for a moment, no harm can result. But often, as I told you, congestion of the head is an incident in diseases of the most serious character, and then the outlook is less hopeful.

Extreme hyperæmia may lead to the rupture of small vessels, to hemorrhage, compression and paralysis. But as the arteries of early life are elastic and strong, and free from the degenerations of structure that are so common in advanced life, such disasters are very rare.

In acute cases of cerebral hyperæmia the treatment should be prompt. Sometimes the congestion is so great and its increase so rapid that a few hours' delay will render all treatment nugatory. The plain indication is to reduce the amount of blood in the head. How shall we do it? The books, even the latest ones, advise blood-letting by leeches or cups, or even venesection. But who actually does this now-a-days? It may be in certain instances the best thing to do; I am not certain that it is not. But little children do not bear losses of blood as well as adults and I think we can manage very well in other ways.

The direct application of cold is known to you all as a ready means of constringing the vessels, and driving, so to speak, the redundancy of blood from the head. To produce this effect the application should be continuous, not intermittent. Cloths wet with cold water, or, if a powerful influence is wanted, bladders of pounded ice may be applied. When there is a thick growth of hair it may need to be cut before you can employ cold effectively.

Another way of diverting blood from the head is by cathartics. To this end

calomel has been more used than any other remedy. It is of small bulk, easy of administration and efficient in action. The saline cathartics are perhaps of equal service.  $\mathcal{R}$  Magnesiæ sulph., 12 grams ( $\mathfrak{z}$  iij.); syrupi sennæ, fl 15 grams ( $\mathfrak{z}$  ss.); aquæ anisi, ad. fl 60 grams (ad  $\mathfrak{z}$  ij.). M. Sig.: Two teaspoons to a child of one or two years.

A diversion from the head may also be accomplished by increasing the temperature of the extremities. Hot foot and hand baths, made hotter with mustard or smart-weed are very efficacious.

The bromides, especially the bromides of potassium and ammonium have been largely used for the last ten or twelve years in cerebral congestion. As you are aware, the claim is made for them that they have the power of diminishing hyperæmia of the nerve centres. They certainly allay the muscular twitchings and restlessness and relieve the headache most happily. Wakefulness may be overcome by combining chloral with the bromide.  $\mathcal{R}$  Potassii bromidi, 4 grams ( $\mathfrak{z}$  j.); chlorali, 2 grams (grs. xxx.); syrupi simplicis, fl 45 grams ( $\mathfrak{z}$  iss.); aquæ menth. pip, fl 75 grams ( $\mathfrak{z}$  ijss.). M. Sig.: Teaspoonful to a child a year old.

We have another remedy of great value in aconite. It is thought to have the power of dilating small blood vessels by paralyzing the vaso-motor nerves. This being so, some of the blood would be enticed from the overcharged head to the other parts of the body. The higher the temperature and the greater the arterial tension the more is aconite indicated. From a fifth to a half drop of the tincture may be given hourly to an infant until free perspiration is induced. It may then be given less frequently.

When the congestion is active and acute the patient should have a spare

diet and be kept in a quiet, darkened room.

The treatment of the passive form differs in some respects from that of the active. While cold to the head and warmth to the legs and cathartics still have a certain value they need not be used so diligently. There is often a cause for sustaining measures. This is especially true when the congestion comes in the course of long, wearing diseases like pertussis.

And when feeble nutrition has caused a sluggish cerebral circulation, try what virtue there is in a generous but digestible diet buttressed by alcoholic stimulants, with plenty of exercise and fresh air.

#### Peritonitis in Newly Born Infants.

Dr. OSCAR SILVERMANN, of Breslau. In newly born infants two forms of peritonitis can be distinguished, a septic or acute, and a non-septic or chronic. The most frequent cause of the latter is syphilis. If the infants are not born dead, they show as symptoms, besides the aged and pinched expression of the face, prominent meteorism and ascites, enlargement of the spleen and liver, increased and shallow respiration and cold extremities. A common result of this fatal peritonitis is atresia ani, less frequently stenosis and atresia of small intestines occur.

The post mortem on the case here referred to, showed complete closure of the duodenum from the pyloric orifice to the opening of the ductus choledochus. The symptoms of a high-seated intestinal atresia, inflation of the abdomen to the naval, sinking in of the part below, distention of stomach, constant vomiting till death, and obstruction, were not present; but the abdominal distention being regular, the vomiting ceasing on the third day, passages of meconium and

stools occurring, and tenderness of the abdomen also being present, the diagnosis of peritonitis was made.

The diagnosis of the septic form is easier, as it arises almost exclusively from infected navel wound. The symptoms are not, however, always constant even in this form, for vomiting and meteorism may be wanting, obstruction or diarrhoea present, and the exudation may sometimes not be felt on account of the meteorism.

The tenderness of the abdomen on pressure is not characteristic as it is also present in dyspepsia, colic, etc.; the pulse generally is frequent but may be slow in weak newly-born infants, the temperature high, but may be subnormal. In the majority of cases there is jaundice, enlargement of the spleen, rapid emaciation and loss of body weight.—*Deut. Medizinal Zeitung.—Obstet. Gazette.*

#### Eclampsia Infantilis.

Prof. WIEDERHOFER (*Vienna Clinic.*)

This nursing has had several attacks of convulsions during the past eight days. Each attack lasts about five minutes, when the child falls into a deep sleep, awakening apparently well. At the commencement the child stiffens, the eyes roll, the extremities extend, the head is thrown back, hands clenched, the face is cyanosed, the breathing becomes superficial, and a soporific condition ends the attack. In seeking the cause we must bear in mind that reflex excitability is oftener the cause of convulsions in children than in grown people. An indigestible meal in the adult seldom occasions more than a feeling of discomfort, while it often calls up frightful convulsions in the child. Convulsions thus originating are of but slight moment. As a positive diagnosis of disease of the brain is ex-

ceedingly difficult in an infant, it is well that it is a rare occurrence, therefore it is important that a thorough examination be made, especially of the bony system. Rachitis gives rise to convulsions in a manner not sufficiently understood. It causes even the convulsions in difficult dentition. Examine carefully the bones of the head, contour of the thorax, and the epiphyses of the forearm. Convulsions complicate most children's diseases. This child has had dyspeptic stools, which fact joined to their continuation decides the conclusion that they are reflex and depend upon colic. Anti ferments, bromide of sodium for the nervous condition, good food, sometimes change of nurses effect a cure. Chloroform inhalations at the outset of an attack. We will give it to child a few doses of calomel, feed it with Biechert's Cream Mixture, gradually substituting cow's milk.

#### OBSTETRICS.

##### Intravenous Injection of Fluid for Hemorrhage.

Dr. C. EDGERTON JENNINGS, in the *Lancet* says: On August 20th, at about 3 P. M., M. A. S., a patient of the London Hospital Maternity Charity, pregnant, and nearly at term, fell in the courtyard adjoining her house, suddenly becoming the subject of profuse ante-partum hemorrhage. At 5 P. M. I found her collapsed to a marked extent, lying on a sofa in her bedroom, the pulse barely perceptible, the skin cold and clammy, extreme pallor of the face, an anxious expression of countenance, sighing respiration, and slight jactitation. Blood was flowing from the vagina; the mucous membranes were blanched. Upon examination, I found the os uteri fairly dilated, the right shoulder presenting; the membranes

were unruptured, and the edge of the placenta could be felt just within the os uteri posteriorly.

At this critical juncture I remembered the cardinal rules laid down very clearly by Dr. Palfrey in his lectures on Obstetric Medicine, for the management of cases of this description—viz., to arrest hemorrhage, to correct the malpresentation with the least possible shock, and, by cautiously employing stimulants and restoratives freely, to allow the patient to rally and deliver herself spontaneously. A drachm of brandy, with one of water, was injected into the gluteal muscles; the membranes were ruptured, and the left leg brought down into the vagina with considerable ease, owing to the flaccid condition of the parts and the amount of general anæsthesia present. The abdomen was kneaded, the hemorrhage ceasing. To have accelerated delivery at this period would, I think, have proved fatal. Two grains of sclerotic acid, in solution, were injected into the buttock, and the woman was covered up with blankets. I left an assistant steadily kneading the uterus, and returned to the hospital for a transfusion apparatus. Not being able to procure a blood-giver, it was determined to try a saline alcoholic intravenous injection.

I may observe, parenthetically, that great difficulty was experienced in finding a vein, owing to the profound anæmia existing. The patient's right elbow was immersed in hot water, and the cubital triangle thoroughly sponged. These means, added to friction of the part and the adaptation of a turn of a bandage around the arm, were successful in causing the veins to stand out with some prominence; an incision was made over the median basilic, the vein exposed, isolated, and an aneurism-needle, armed with a double ligature,

passed beneath it. The distal ligature was tied, the vein opened, the nozzle of a three-ounce metal syringe, charged with the fluid already prepared, inserted; the proximal ligature tied loosely over the nozzle of the syringe, and the piston pressed slowly home. This was about 6 P. M., the woman being moribund. The syringe was emptied; it was disconnected, refilled and readjusted, the process being continued till sixteen ounces of fluid had been injected. Signs of animation very rapidly appeared—recognition of people present, speech, vision and hearing returned, and complaints of pain in the abdominal region were made. The syringe was withdrawn, the proximal ligature on the vein now tied tightly the wound closed with the interrupted suture, and a compress and bandage applied. Another grain of sclerotic acid was injected hypodermically, and the case left to nature, delivery occurring at about 7:30 P. M., without any further operative interference whatever.

I may add that the saline alcoholic solution employed in this case consisted of twenty ounces of water at about 100° F., into which was stirred a powder containing exactly the following ingredients: Chloride of sodium, fifty grains; chloride of potassium, three grains; sulphate of soda and carbonate of soda, of each twenty-five grains; phosphate of soda ( $\text{Na}^3\text{Po}^4$ ), two grains. To the fluid thus prepared two drachms of absolute alcohol were added. The subsequent progress of the patient has been most favorable. The highest temperature (Aug. 23d) noted since delivery was 102.4° F.; the wound at the elbow healed kindly, and the woman has proceeded to an uninterrupted convalescence.

I believe I am correct in asserting that transfusion is commonly regarded

as a theoretical rather than a practical operation—as one to be performed in the theatre of a hospital, but not in the country village or wayside house. With the view of facilitating the method of intravenous injection, Messrs. Maw, Son, and Thompson, have made for me a small case containing a few feet of elastic tubing, to be used after the principle of a nasal douche or syphon, canulæ of different sizes, a pair of dissecting forceps, with fine points, a scalpel, an aneurism-needle and ligatures, a graduated bottle for alcohol, and room for some saline powders. Here, within very small compass, the accoucheur has the means, with the addition of a jug of hot water, of combating very speedily the effects of alarming hemorrhage. This is, I submit, a more practical method than the transfusion of blood; here no blood donor is required, and no risk—it may be urged a trifling risk—to a healthy life incurred.—*Ibid.*

#### Prof. Verneuil on Transfusion.

During a discussion on this subject at the meeting of the Association Française, at Rochelle (*Gaz. Hebdomadaire*) Prof. VERNEUIL expressed his opinion that transfusion is often a very difficult and dangerous operation, and almost always a useless one. In place of occupying ourselves with the mechanical procedures of the operation, it would be better to consider its physiological pathology, its indications, and its contra-indications. It is not always followed by death, and in some cases it seems even to have saved the patient; but fortunate results are only observed when a very small quantity of blood has been injected. It is not by its globules, by the elements of nutrition which it furnishes to the tissues, that injected blood acts, but by a general dynamic reaction which it induces by its contact with the

endothelium of the vascular system. Ether injected into the cellular tissue produces the same reaction, arousing the exhausted organic forces. In presence of the difficulty of the operation, and the defects of the apparatus in use, Prof. Verneuil prefers the ether injections, all the more as he does not believe that there exists a case on record proving that transfusion has succeeded where all other means have failed.—*Medical Times and Gazette.*

#### Ether Injections vs. Transfusion.

From the *Gaz. des Hôp.* we learn that Professor HAYEM recently read a paper before the Académie de Médecine, in which he related the results of his experiments, in controversion of the accuracy of Prof. Verneuil's statement that transfusion is a useless operation, which may be superseded by hypodermic injections of ether. Having bled a dog almost to the point of death, he found that the injection of ether was attended with no durable effect, while transfusion produced a "true resurrection." When a large quantity of blood was withdrawn, the dilation of what remained by the transfer of the serum derived from another dog was also attended with the same success. The stimulation by ether only produces an increase in the energy of the cardiac contractions and a notable increase in the number of the pulsations, but does not give rise to any increase of the pressure of the blood nor of the rectal temperature.—*Med. and Surg. Reporter.*

#### The Entrance of Air Into the Venous Circulation,

While comparatively a rare occurrence, has long been recognized by the profession as a cause of sudden death. Dr. F. W. DRAPER reports two cases

(*Boston Medical and Surgical Journal*) in which sudden death from this cause followed attempts to produce abortion. In one case the attempt was made by the woman's paramour, in the other by a physician, and in both the instrument used was thought to be a catheter. The results of the autopsies are interesting, in that they showed an almost identical condition of things in the different organs in both cases. It was found on making an incision over the sternum that air escaped from the divided vessels. The pericardium in each case was distended, the right cavities of the heart were enlarged, and on making a small puncture into the ventricle a puff of air, without odor, escaped. The left cavities were contracted and empty. The lungs were congested, the kidneys hyperæmic, the livers healthy, but on cutting into them bubbles of air came from the vessels. The inferior venæ cavæ were almost entirely filled with air instead of blood, and the uterine and iliac veins also contained air. On cutting into the uterus of the first case an ovum of three months was found, and one of seven or eight months in the other. It was found that the instrument had not passed into the amniotic cavity, but had torn the decidua from the uterine walls, and exposed the mouths of the sinuses, and had thus allowed the air to enter.—*Weekly Med. Review.*

#### Strict Antiseptic Midwifery

Is practiced in the British Lying-in Hospital, according to the *British Medical Journal*. Each patient is delivered under a carbolic spray of one in sixty; she is twice daily syringed out with a two per cent. solution from the first day after labor. Every patient receives three times a day a mixture of ext. ergotæ liq. gtt. x. tr. opii gtt., v.; quiniæ sulph.,

grs. ij.; acidi phosphor. dil. gtt., x.; aquæ, ʒi. According to the presence of any idiosyncrasy in the patient, this mixture is modified. In each ward of the hospital there is continually playing a carbolic spray of one in eighty. All washings of the genitalia are done with a one and sixty carbolic solution. The beds consist of horse-hair mattresses, on springs. Each ward contains four beds and is disinfected with burning sulphur, the floors being washed over with carbolic solution after three relays of four patients.—*Ibid.*

#### Rupture of the Aorta During Parturition.

Dr. HEINRICIUS relates the following case: A woman, thirty-eight years of age, of apparently good health, was first seen after labor had begun. The os was dilating, the pains were regular, and everything seemed to be progressing favorably. Half an hour later she was suddenly seized with convulsions and died in collapse. A living child was delivered with the forceps. At the autopsy a rupture of the aorta was discovered, situated about three-fifths of an inch above the semilunar valves. The visceral layer of the pericardium was torn, and the pericardial sac was distended with blood.—*Centralblatt für Gynäkologie.—Med. Record.*

#### Rupture of the Funis

In utero is not a frequent occurrence; but Dr. J. D. TALBOT records a case (*Miss. Valley Monthly*) in which the cord was torn off within a half inch of the body. The child lived twenty hours. He thinks the cord, which was thirteen inches long, was probably coiled around some part of the child's body, and was ruptured at the time when the waters escaped.

## DISEASES OF WOMEN.

## Malarial Metrorrhagia.

Dr. J. J. HENNA, (*Med. Gazette.*) A case of uterine hæmorrhage presenting itself as such would raise in our minds the thought of perhaps a dozen or more different causes, but would not be likely to suggest at all the idea that it might be due to malarial influence. Though if we met with a case of fever and ague, in which, beside the chill, fever and sweat, there was a periodical bleeding from the womb, we would have no hesitation in at once recognizing the cause and remedying the difficulty.

Isolated symptoms, however, of disease generally presenting well characterized manifestations, are very apt to be mistaken, and the true cause to be overlooked, and I think that, perhaps, the clinical histories here related may enlighten us somewhat on a subject, which, as was previously remarked, has been either unknown or entirely neglected by those who look on it from their own peculiar standpoint, a point of view, moreover, from which it would be most likely to be observed, namely, the gynaecological.

Mrs. S., a native of the U. S., 36 years of age, married fourteen years; no children. Her menses appeared when thirteen, and have always been very regular up to two years ago, when she suffered from intermittent hæmorrhages as at the present time. Is quite emaciated, weighing only 95 pounds, pale, and very depressed in spirits. Has been treated by a specialist for uterine displacement, to which the doctor attributed her sterility. Two weeks before she called on me she noticed that her courses had come three weeks earlier than expected, and that she would be taken sick about four o'clock every after-

noon, and at or about eight o'clock in the evening she would again be well. Associated with this trouble she felt pain in the region of the uterus, which she compared to the pains in the temples from "tic douloureux," *i. e.*, like neuralgic pains; felt chilly and desired to lie down. Her appetite, which was never very good, was less than usual. But she felt better in the morning, and could not understand why she should be taken unwell every day, and for a few hours only. On examination (ten o'clock in the morning), I found the uterus ante-flexed and slightly enlarged, but not extra sensitive to the touch. With the speculum I perceived no high coloration of the cervix, and the sound passed in with very great difficulty. There was neither granular nor cystic degeneration of the cervix, and independent of a slight mucous discharge, I considered her in as good a condition as her ante-flexed uterus would permit. I therefore concluded that she was suffering from that form of metrorrhagia which I had before met, and which I could not classify among those usually recognized. Ordered injections of hot water, rest, ergot and nux vomica. Two days later, she called again, to say she felt no better, and repeated her original remarks: that she was well until about four o'clock in the afternoon, but after that hour she felt the pain in the uterus, chilliness, and the flow began. On her previous visit she had neglected to mention that, two years before, she had, at her husband's suggestion, taken a sea voyage, in the hope that it might bring the relief to her distressing symptoms which all the means which she had tried had failed to do. *To her surprise this gave her complete relief, and she returned home entirely well.* She was the more anxious and worried about her condition at the present time, as it would very se-

riously inconvenience her to repeat the trip, and she had no hope of relief in any other way. This most important information—her recovery after the sea-voyage, associated with the periodicity of the hæmorrhage—suggested to my mind the idea of malaria. I therefore resolved to try the usual method of combating that protean intruder, and began with a full dose of quinine. Twenty grains were administered at bedtime, and ten early in the morning. The drug showed no clemency to the poor lady's shattered nervous system. I found her at five o'clock in the afternoon entirely cinchonized, trembling as in paralysis agitans, deaf, and in a high degree of hyperkænesis. *But there was no hæmorrhage.* Ordered food to be taken at once, believing as I do, that more good is obtained from food in cases of cinchonism than from the empirical dose of bromide, and promised to return the next morning. I called at eleven A.M., and to my discouragement, I heard that about 9 A. M., the flow had begun again. The fact that I had been able to postpone the attack, however, gave me renewed hope of success at my next attempt to stop it. I ordered the same dose of quinine, 20 grains, to be taken as soon as the flow stopped. At 12 o'clock there was no more blood, and she took the quinine, and also 10 grains the next morning. The day passed and there was no hæmorrhage. Ten grains more of quinine at night, and ten the next morning, as much food as she could take to mitigate cinchonism, the battle was gained, and I was enabled to carry to my book of record an interesting observation which I never heard of before. She continued to take small doses of quinine for a week longer, and her appetite returning, she was again re-established in her usual health. Six weeks after, however, I had her again on my

hands with a similar attack, but this time the quinine did its work quickly, and to prevent further recurrence of the same, on my advice she removed from the premises where she was living, and since then, about a year and a half, she has had no return of the trouble.

The second case was a Cuban, Mrs. R., 24 years of age, married eight years, two children, the youngest  $4\frac{1}{2}$  years old, now sterile, probably on account of a very severe form of cervicitis associated with a small laceration of the cervix. The first time she noticed the hæmorrhage was while in the country a year ago last summer, at Rahway, N. J. Towards evening she felt pain in the uterus, a flushed face, palpitation of the heart, prostration and chilliness, and then a few drops of blood would show themselves for a few hours. After a while the symptoms began earlier and earlier, until she had two attacks in one day very much resembling the anticipating type of our malarial fevers.

Encouraged by my former case, and the periodicity being so well marked, I lost no time in combatting it as of malarial origin, and, after a full dose of quinine and the continuance of the anti-pyretic drug for a few days, she was again restored to her usual health.

The third and last case, is that of Mrs. McC., an American, of Irish parentage, widow, 38 years of age, and of robust and plethoric constitution, the mother of one child, a boy 17 years old. This case had the peculiarity that the uterine hæmorrhage alternated with attacks of epistaxis, but the periodicity was never well established; at least I was never able to ascertain whether it was the quotidian, tertian, or quartan type. It was, however, sufficiently marked to put me on the track of its cause, and the sulphate of quinine, as in

the preceding cases, did its work well, and in a short time.

We all know that malarial poisoning takes place through the circulation, be it by inspiration or by absorption of *bacteria and fungi*, introduced into the stomach with the food and drink. "The blood," as says Hurtz, "is only the vehicle for the poison which, by hyperæmia and destruction of blood corpuscles in such organs as are disposed thereto, may occasion at such points, the local development of pigment matter." We have recognized congestion in almost all the viscera due to malarial poison. The spleen I believe to be the favorite one. Then the liver, the lungs, the brain, the stomach. The mucous membranes are also favorite places of malarial congestion.

Assuming Hurtz's supposition to be correct, we may explain the influence of malaria in producing the phenomena in question, that by paralyzing the vasomotor nerves, in the coats of the vessels of the uterus, a hyperæmic condition is produced; then, again, to the influence it exerts on the red corpuscles, which disintegrates and transforms them into pigment, and to the diminution of the albuminoid elements, the nutrition of the walls of the blood-vessels is therefore lowered, and they are consequently exposed to breaking. But how does malaria produce this vaso-motor paralysis? It is an accepted theory that the pigment matter produced by malarial poison in the blood has a predisposition for the capillaries, and as it carries with it the poison, penetrates their walls and forms true capillary aneurisms, which in their turn press upon the nerves and paralyze them. Or we may have œdema exerting a like influence over the nerve peripheries. These cases, I hold, elucidate the fact, that metrorrhagia is sometimes produced by malaria, and exem-

plify how some cases of that affection may be remedied, which otherwise would baffle our efforts for relief.

[During the past ten years we have taught our students that menorrhagia and amenorrhœa are frequently traceable to malarial poisoning, acute and chronic. The former yields promptly to quinia, and the latter to quinia and arsenic.]

A. J. C. S.

#### Chronic Ovaritis.

Although not so frequently occurring as some of the other disturbances of the uterus and its appendages, as, for instance, version, prolapsus, endo-metritis, endo-cervicitis, etc., chronic ovaritis is sufficiently common to cause much trouble and anxiety to the practitioner. It is a very unsatisfactory affection as regards treatment, and any suggestions bearing thereon are always in order. We have a number in an article by Dr. HENRY GERVIS, obstetric physician to St. Thomas' Hospital, London, in the *British Medical Journal*. We have in the history of a case reported by him a very succinct narration of the symptoms of chronic ovaritis. The principal one is pain in and radiating from one or other ovarian region; more or less severe; sometimes dull, sometimes acute, sometimes very acute. At first this pain is occasional only, but apt to be pretty regularly provoked by the occurrence of ovulation, getting worse before the catamenia and lessening afterwards. After a time it becomes continuous, but increased by standing or walking; especially is this the case if the ovary be prolapsed or congested; and if it be the left ovary which is affected it is apt to be aggravated before and during action of the bowels. So great is the pain under the latter circumstances that the patient will

sometimes defer defecation for one or two weeks, and in one of Dr. Gervis' cases even three weeks were allowed to pass through dread of the pain. In the early stages of ovaritis there is a tendency to menorrhagia, but later on, owing to changes in the tissue, the flow usually becomes scanty and is accompanied by pain (dysmenorrhœa). The pain on pressure over the diseased ovary is of a sickening nature, resembling, indeed, the pain caused by pressure on an inflamed testicle. Among the constitutional symptoms the chief are neurotic disturbances and nervous irritability, the result of nerve exhaustion.

As regards treatment, it must be remembered that uterine trouble usually precedes the ovarian, and the former must be rectified before the latter, *per se*, can be benefited. The bowels must be maintained in a soluble condition, and much benefit will be derived from injections twice daily of hot water (100° to 110°) and the introduction of pledgets of cotton saturated with glycerin high up in the vagina. All pressure from the clothes must be guarded against, as must also all pressure from accumulation of flatus. Rest in the recumbent posture, within the limits of physiological necessities, must be enjoined, the hips being raised by a pillow. The iodide of potassium for its effect on the inflamed tissue, the bromides of potassium and ammonium for the nervous disturbances.

The local treatment includes the use of iodine or small blisters to the inguinal region, or sedative liniments, such as the liniments of aconite, belladonna, or chloroform. Hot sitz baths, douches, 105°-110°; mercurial vaginal suppositories where it appears possible to promote absorption of exudations, or lessens ovarian congestion; and when the ovary is prolapsed, the introduction of an elastic ring pessary, which supports at

once both uterus and ovary, often so taking off the dragging and bearing-down sensations of which the patient complains, and markedly relieving the dyspareunia so frequently present. A device that Dr. Gervis has made use of sometimes, and with benefit, has been what has been called the postural method of treatment. By getting the patient to kneel for definite periods of fifteen to thirty minutes, two or three times a day, in the genu-pectoral position, the ovaries, unless fixed, will gravitate out of the pelvis, and so lose some of their congestion. And these approaches to a healthy condition, repeated frequently, lead, it is believed, to the tendency toward health becoming permanent. At all events, this position very frequently has the effect of distinctly relieving pain. One other point worthy of attention is the question of utero-gestation, and the cognate one of the permissibility of conjugal relations in the married. Briefly, sexual excitement being obviously undesirable, intercourse must be within the most restrained limits, when, from circumstances, complete abstinence is unattainable. In some stages of ovaritis, while ovulation proceeds, conception is, of course, possible; and there is also no doubt that gestation has in many cases been distinctly beneficial to cases of chronic ovaritis. The explanation being that during gestation the ovaries are having a complete physiological rest; and also that being lifted out of the pelvis by the uterus, as it rises in the abdomen, they are removed from much of the pressure and weight to which, while in the pelvis, they are subjected. But in spite of all such precautions and treatment, a certain number of these cases drift into the third class, the class in which no remedy short of a nearly persistent narcotism appears to give any

relief. The patient is always in pain; pain spoken of by some as a burning, scorching pain; by others as a wearing unendurable pain; by others as "torture;" a pain from which nothing but the stronger sedative, or hypodermic injections of morphia, or large doses of brandy, give any freedom. For the relief of this class little but surgical treatment remains, apart from the perpetual administration of sedatives.—*Med. Age.*

#### The Causes and Treatment of Pruritus Vulvæ.

In a clinical lecture on this subject (*British Medical Journal*) Dr. WILTSHIRE mentions the animal and vegetable parasites as frequent local causes of this condition. Ascarides, pediculi, and acari are among the former, and certain low forms of vegetable life, as thrush fungus (*oidium albicans*), among the latter. Among other local causes we have—1. Diseases of the vulva (as vulvitis, abscess, carcinoma, oozing tumor, lupus, elephantiasis, etc.); 2. Diseases of the urinary system (urethra, bladder, and kidneys); 3. Vaginitis (gonorrhœal and other); 4. Diseases of the uterus (metritis, endometritis, senile catarrh, cancer, fibroids, polypi, acrid discharges arising from the foregoing or occurring mainly in association with menstruation); 5. Skin affections (eczema, ecthyma, herpes, urticaria, acne, etc.) As regards the latter, eczema may be associated with diabetes, producing terrible suffering, while urticaria suggests ovarian disease. Ecthymatous spots with ashengray bases may indicate grave cachexy (syphilitic?); while the herpetic vesicles are prone to crop out periodically in females of gouty parentage just before each menstrual period. A pustular form of acne is sometimes accompanied by troublesome itching. Venereal warts may excite itching.

Malignant disease of the uterus and upper part of the vagina may provoke itching in two ways: First, by acrid discharges; and secondly, reflexly—the latter uncommonly. The same may be said of fibroids, polypi, sarcomata, etc. Dr. Wiltshire has known pruritis to exist for a long time apparently as a consequence of pelvic effusions, *e. g.*, hæmatocele, cellulitis, partly, perhaps, from venous obstruction and partly from implication of nervous structures. Some discharges from the womb are virulently acrid, and excite excoriation of the parts over which they flow. These are revealed by the speculum. Urethral and vesical affections—*e. g.*, vascular growths, stone, incontinence, etc.—are sometimes complicated by vulvar itching. Careful local investigation is therefore necessary; for even when some general condition, as diabetes, is present, the local condition may give valuable information.

Among general causes we find diabetes, pregnancy, gout (or lithiasis), syphilis, and pruritus senilis. Diabetes is not an uncommon cause, and vulvar pruritus may be one of the first symptoms which lead to its detection. Pregnant women are liable to a severe form of pruritus vulvæ, accompanied usually by an abundant creamy discharge. Sometimes aphthæ or erosions are seen upon the turgid labia or cervix, or there may be vaginitis granulosa. Most of the cases which Dr. Wiltshire has seen have been accompanied by extreme venous turgescence. Gouty pruritus is apt to be brought on by indulgence at the table of any diet which increases the deposit of lithates in the urine. Chancres and venereal warts [which last Dr. W. apparently considers syphilitic.—*Ed.*] may provoke irritation. Pruritus senilis is often associated with general cutaneous hyperæsthesia. Klob says there are little elevations of the skin, like

goose flesh, consisting of growths analogous to tubercular formations, and giving rise to violent itching. These cases are grave. Some are amenable to the bromides used locally as well as internally. Arsenic and cod-liver oil are also indicated.

All forms of pruritus vulvæ are subject to periodical exacerbations. Some patients suffer only at night, after becoming warm in bed, experiencing comparative freedom during the day. All who menstruate are conscious of aggravation at that time. Stimulants, as a rule, exert an injurious effect. Sedentary occupations, piles, and hepatic disorders aggravate pruritus.

*In the treatment of Pruritus Vulvæ*, Dr. Wiltshire says that the first thing is to find, if possible, the cause. Extreme cleanliness must be enjoined. Demulcent washes are better than soap; unless carbolic or coal-tar soap be used; and usually even these are inadmissible. Almond meal, strong bran-water, decoction of rice, marsh-mallow, slippery elm, or fine oatmeal are suitable, especially the first, which, if pure, yields during use a marked odor of hydrocyanic acid and appears to soothe materially. When the pruritus is due to animal parasites, ointment of white precipitate, sulphur, or stavesacre speedily cures by destroying the insects and their ova. If nits persist about the pubic hairs, a lotion containing bichloride of mercury and acetic acid will dissolve them. Ascarides are destroyed by a carbolic lotion (1 to 60): general treatment, however, should be used, as iron, quinine, cod-liver oil, together with enemata of hamamelis, lime water, iron, etc.

The vegetable parasites are treated by washes of borax, boracic acid, sulphurous acid, etc. Parasiticide lotions are certainly the most useful in the majority of cases, which points towards vegetable

organisms as the commonest cause of the pruritus. The borax lotion should be of the strength of a drachm to five ounces of warm water, or stronger; hydrocyanic acid, say 3 j of the dilute acid, to water 5 x, or morphia (2 gr.), atropia ( $\frac{1}{2}$  gr.), aconitia ( $\frac{1}{2}$  gr.) or veratria ( $\frac{1}{2}$  gr.) to the same amount. Infusion of tobacco (half an ounce to the pint) alone relieves some cases, and forms a good vehicle for borax or boracic acid. It is not well to use glycerin with the borax, as a rule, as it is apt, owing to its affinity for water, to aggravate the irritation. Strong solution of poppy is a good vehicle for borax. Chloral frequently does not suit. Ice suits some, very hot water others. In some cases ether spray might be tried. Ointments, if used, should be of non-rancid fats or cosmoline. Two drachms of iodine [tincture?] in two ounces of elder-flower water sometimes answers. Electricity may afford relief in neurosial cases. Probably faradism would be the preferable form.

In simple vulvitis, borax or carbolic acid lotions relieve. An ointment of calomel or bismuth is also good. Malignant affections of the parts call for ablation, but where this is not practicable sedative applications (conium, opium, belladonna) alone are often all that we can employ.

Of course urethral carbuncles, urethritis, vaginitis, etc., should receive thorough treatment. When there is congestion with loading of the portal circulation a mercurial and saline purge is helpful. When eczema with fissure is present, a poultice made of the clot formed by adding two drachms of lead-water to ten ounces of new milk is most useful. Diabetes must of course be combated, and frequent ablutions with borax washes from a good local treatment. In wakefulness from diabetic

pruritus, codia in one grain doses in pill is often useful. The bromides are also useful.

Pregnant women often suffer terribly. When *oidium albicans* is present, sulphurous acid gives relief. A tablespoonful should be freshly mixed with half a pint of warm water, barley-water, or almond emulsion for each application. Chloroform locally, in liniment, ointment, lotion, or vapor, answers well occasionally; bichloride of mercury, gr. iv., ad  $\frac{3}{4}$  viij. mist. amygdalæ, gives relief in some cases. It should not be used when there is abrasion. Section of the pudic nerve has been suggested in desperate cases, but has never been practised.—*Philadelphia Medical Times*.

#### Pigmentation of Cervix Uteri.

In the report of the Pathological Society of London (*British Medical Journal*), Dr. ROBERT BARNES draws attention to an unusual condition which he had observed in a case of hypertrophic elongation of the cervix uteri. The specimen, which consisted of the two lips of the cervical portion of the uterus, had been removed from a Hindoo woman. The surface was remarkably pigmented; a patch of the color of the woman's skin occupied the mucous membrane, where, owing to the exposure produced by the disease, it had become dry. The microscopical examination presented the usual appearance of the skin and showed conspicuously the various laminae. The pigmented granules were seen to lie in the normal cells of the rete mucosa, and appeared to occupy the nuclei.—*Chic. Med. Rev.*

#### Uterine Ulceration.

*Oil of Ergot*.—Dr. J. V. SHOEMAKER, of Philadelphia, says: Before concluding these remarks upon oil of ergot,

I should add that I have found it equally efficacious in various affections of the mucous membrane.

Applied with a piece of cotton in ulceration of the cervix uteri, the oil of ergot has acted with great promptness. *Med. Herald*.

#### Superinvolution of the Uterus.

Dr. SINCLAIR, at a meeting of the Boston Obstetrical Society (*Boston Medical and Surgical Journal*), reported a case of what he regarded as uterine superinvolution. The woman was twenty-six years old, and, after the third child-birth, she ceased to menstruate. Although plump and well, she was very nervous. There had been no menstruation for a year when she consulted Dr. Sinclair, who found an extremely small, infantile uterus. This would not admit a small uterine sound, but a probe could be passed up two and a half inches. She is now thirty-six years old. A year ago the husband had called to say that his wife was in charge of a physician who said that the trouble was due to a ruptured perineum and lacerated cervix. Dr. Sinclair claimed an examination in his own defence, and found no laceration whatever.—*Med. Record*.

#### Pathology and Treatment of Uterine Displacements.

The following practical points are set forth by SCHULTZE, in a recent monograph upon uterine displacements: The normal condition of the uterus is one of very free movement, as can be readily demonstrated in the living subject. Changes of position that are permanent are pathological deviations. Restriction of normal movements is the characteristic sign of displacements. These consist in (1) fixation of the organ through inflammation, and (2) malposition resulting from relaxation of the ligaments.

In the first class, treatment should be directed against the inflammation, in the second, the weakened ligaments should be assisted by mechanical means. Dysmenorrhœa and sterility in ante flexion and anteversion arise not from change of position, or supposed stenosis, but are due wholly to the coexisting metritis or parametritis. Treatment should be directed against the inflammation, and not against the assumed stenosis or the malposition. In retroflexion, on the contrary, mechanical treatment is indicated.—*Berliner Klin. Wochenschr.*—*Ibid.*

#### **Puncture of Gravid Uterus During Ovariectomy.**

At a recent meeting of the New York Obstetrical Society, Dr. C. C. LEE related the following case (*New York Medical Journal*): A patient, twenty-eight years of age, was sent to the Woman's Hospital by Dr. Hanks, for the removal of an ovarian cyst situated on the right side. The presence of the cyst was supposed to have been the cause of several miscarriages, and, as the patient was then three months pregnant, it was thought likely to prove so again. After making the usual incision for ovariectomy, the exact relation of the tumor to the uterus was ascertained. In turning the patient on her side, preparatory to puncturing the cyst, the latter was let go, and, unknown to Dr. Lee, the uterus took its place, rolling up into the abdominal incision, and was punctured instead. A large trocar penetrated the body of the womb to a depth of about two inches, entering at a point about two inches below the fundus. No fluid escaped when the trocar was withdrawn. The uterine wound was sewed up with carbolized silk, the long pedicle of the ovarian cyst was then ligated, the cyst was removed, and the abdominal wound

was closed. Abortion had not occurred, and the patient was doing well. There had been vomiting, which was probably due to the influence of the anæsthetic. It was a noteworthy fact that the pedicle in this case was so long that the tumor, which was developed from the left ovary, lay upon the opposite side, in the region of the right ovary. Dr. Lee thought the silk-worm suture, which was used to close the abdominal wound, possessed no advantages over the carbolized silk ligature. It was much more liable to break, and was less easy to handle.

[This case is valuable because instructive. Honest records of accidents and failures teach more than histories of successes.]

A. J. C. S.

#### **Electrical Stimulation of the Uterus.**

The *Lancet* says that the influence of electricity on the uterus, whether empty or gravid, is a point on which authors have made various statements. The difference of opinion may be due to the circumstance that the conclusions have been drawn from the somewhat uncertain field of clinical observation. M. DEMBO, in a note presented to the Académie des Sciences by M. Vulpian, has endeavored to decide the question by experiments on animals. His observations at present relate only to the non-gravid condition. In the rabbit, direct faradization of the uterus or of one of its cornua causes a contraction at the point to which it is applied, and which extends for a distance of about twenty millimetres, but never reaches the other cornu. If one electrode is applied to each cornu, both can be made to contract in the neighborhood of the poles, but not in the interval between them. Very different, however, is the effect when the application is

made to the vagina. If both electrodes are applied to the vesical wall of the vagina, a manifest contraction is produced in both parts of the uterus, vermicular in character, passing from below upwards. If the application be made to the lateral portions of the vaginal wall, a contraction is produced only in the corresponding cornu. Local contractions on the corresponding side can be produced by placing the electrode on certain points in the broad ligament, but the contraction never extends to the whole uterus. It is impossible to produce contraction of the non-gravid uterus by faradization applied through the abdominal wall. The excitability of the uterus of the rabbit was found to vary according to the age of the animal, and according to whether it had borne young or not. That of a young animal is so irritable that manifest contractions are excited by mere exposure to the air, but in old rabbits the uterus is much less susceptible. In some dogs and cats no contraction of the empty uterus could be obtained by faradization, in others slight contractions with distinct pallor were produced. Faradization of the vaginal wall caused pallor of the mucous membrane, and also of the whole uterus, due apparently to contraction of the vessels, but no contraction of the substance of the uterus. Frankenhauser found that stimulation of the aortic plexus caused a manifest contraction of both cornua, and it is highly probable that an analogous nervous plexus is situated in the vesical wall of the vagina. The observations were made on animals under the influence of either chloral or curara.—*Med. & Surg. Reporter.*

## DISEASES OF CHILDREN.

### The Temperature in Measles.

From the study of a large number of cases of measles occurring in the Bicêtre, in the section of epileptic children and idiots, Drs. BOURNVILLE and BONNAIRE (*Progrès Médical*) have been enabled to make some interesting and important observations. The temperature was carefully and systematically recorded, with the following general results:

The *period of incubation* could not be exactly assigned, on account of the rapid development of the epidemic, and on account of the defective mental condition of the subjects. The *prodromic period* was better observed, and in a number of the cases a gradual and progressive evening rise in the temperature, with morning remission, was found. During this period the maximum temperature was  $40.4^{\circ}$  ( $104^{\circ}$  F.), but generally the temperature oscillated between  $39^{\circ}$  and  $40^{\circ}$ . Wunderlich also noticed this early rise, and stated that "only very exceptionally does the fever at this stage ever attain to the maximum of the entire disease." It is soon followed either by a fall of from  $.4^{\circ}$  to  $.8^{\circ}$ , or by a stationary period during which it remains steadily at a fever temperature. When there is a rapid fall it might lead to the idea of the existence of an ephemeral fever, where the other symptoms are not sufficiently marked to guard against this error.

After this remission, or stationary period, there comes soon a new elevation of temperature, corresponding to the *period of eruption*. The temperature soon attains its maximum ( $40^{\circ}$  to  $41^{\circ}$ ), which exceeds slightly the early rise, though usually not more than a few tenths of a degree. This elevation is rapid, and the maximum is reached in

twenty-four hours; rarely does it require two days. The highest temperature almost always coincides with the general extension of the exanthem, as affirmed also by Wunderlich. After this there is a fall. The *period of defervescence* in some cases immediately succeeds, and becomes continuous with this fall consecutive to the fever of eruption. In other cases the temperature again sustains a temporary elevation, though not so high as before, and for several days oscillates between  $38^{\circ}$  and  $40^{\circ}$ . In such cases, however, there are likely to be complications, or at least a persistence of the symptoms of the first period. The authors especially insist upon the importance of clinical thermometry as furnishing early indications of the appearance of complications.—*Med. Times*.

#### Alcohol in Scarlatina.

Dr. GILES MITCHELL reported to the Cincinnati Academy of Medicine forty-three consecutive cases of scarlatina treated with large doses of alcohol, without a single death. A half ounce of whiskey every hour was given to a child two years old for a number of days, without the slightest sign of intoxication. When the kidneys became implicated the alcohol was still used. It always produced a fall of temperature. The report is found in the *Medical Times*.—*Med. and Surg. Reporter*.

#### Chamomile in Infantile Diarrhœa.

Dr. CHRISTOPHER ELLIOTT, Physician to the British Hospital for Sick Children (*Practitioner*), endorses Ringer's claim for the great value of infusion of chamomile in infantile diarrhœa connected with dentition, and in which the stools are many in number, green in color, or are slimy and streaked with blood, and accompanied by pain and cramp. He gives 3 ss.—3 j. of the infusion to a child

under one year, and double to quantity to a child over that age, giving it three times a day or oftener, according to the severity of the attack. He explains the rationale of this treatment by the power which chamomile flowers possess of subduing reflex excitability, a power residing in the volatile oil contained in them. Grisan was unable to tetanize, by means of strychnia, a decapitated frog which had been fortified with a dose of chamomile oil, and *vice versa* when reflex excitability had been artificially produced by means of strychnia, it could be calmed again by chamomile oil.—*Med. Age*.

#### Cholera Infantum.

If an infant is taken with vomiting and frequent watery evacuations—cholera infantum—give Fowler's sol. in perhaps 1-10 drop doses, with but little water, and repeat the dose as often as the child shows any indication of nausea.—*Med. Index*.

#### Tabes Dorsalis in Early Childhood.

Dr. G. LEUBUSCHER, in the *Beliner Klin. Wochenschrift*, reports the following case of locomotor ataxy, occurring in a child only three and a half years old. The patient was brought to the Jena Policlinic by his parents, who stated that for six weeks past the child had been unable to walk. He had always been a healthy boy, though he stuttered. There was no history of nervous diseases or of syphilis in the family. The boy complained of no pain; there was no strabismus and no disturbance in the functions of the bladder or rectum. Intelligence was unimpaired. The legs could be raised from the table, flexed and extended. Tendon reflex, and foot clonus absent, skin reflexes normal. The patient was unable to stand or walk alone, and, when assist-

ed by the hand, exhibited a typical ataxic gait. There was also commencing ataxia of the upper extremities. Slight improvement seemed to follow galvanization with a mild ascending current.—*Med. Record.*

#### Rectal Examination in Vesical Calculus.

The Edinburgh *Medical Journal* calls attention to R. VOLKMANN'S article in *Centralb. für Chirurg.* In children suffering from vesical calculus a bimanual method of examination through the rectum and above the symphysis is of great value. Anæsthesia is necessary and the abdominal walls should be thoroughly relaxed. The fingers of the left hand in the rectum raise the stone, the bladder being empty, and the right hand guides it to the symphysis pubis. If the stone is not too large, it may be so far raised that a string could actually be passed around it. In adults the operation, of course, would not be so successful.—*Weekly Med. Review.*

#### Effect of Narcosis on the Urine of New-born Children.

Prof. HOFFMEIER, Berlin. *Deut. (Med. Zeit.)*

In eight cases of labor, in which narcotics were used, the author found the urine of the new-born child more or less colored according to the amount used. In thirty-four cases, in which none was passed, the urine in twenty-two was not the slightest colored, while in twelve it was slightly colored. The elimination of the urinary constituents in such children is greater immediately after birth than in those born without the use of chloroform. It also reaches its maximum twenty-four hours earlier and remains richer in the urinary salts and uric acid for the first week.

Narcosis also causes an increase of albumen in consequence of the hypere-

mia of the kidney, a result of the increased urine elimination.

He also found in the urine of children born while the mother was under the influence of chloroform, a peculiar pigment, in form of flakes and cylinders, dotted with black points; the author holds it to be changed blood extravasations. The loss of weight in such infants showed no difference in comparison with others.

His conclusions are, that narcosis in labor causes an increased elimination of urine and its constituents, in the first days of infantile life.—*Obstet. Gazette.*

#### Meningitis Tuberculosa Cured by Applications of Iodoform.

According to CÜSFELD'S method, Bauer treated a five year old female child with applications of iodoform in ether, and effected a complete cure thereby.—Bauer, *Deut. Med. Wochenschr.*—*Ibid.*

#### Expulsion of Four Hundred and Forty-one Lumbricoid Worms within Thirty-four Days.

Dr. A. C. POLE, of Baltimore, reports (*Medicine Chronicle*) the case of a girl aged seven, who had been complaining for months of nausea and colicky pains in the abdomen. The skin was icteric, appetite variable, bowels costive. She was treated for worms and was given santolin, chenopodium, etc. Within thirty-four days four hundred and forty-one lumbricoid worms were passed, in "lots" varying from one to thirty-five. Dr. Pole says: Larger numbers than these have been reported, but such a number in so short a space of time I believe to be infrequent. Ransom in his article on intestinal worms, says that cases are recorded in which various numbers, from one hundred to twenty-five hundred, have been expelled from one person within a few months.

Cruveilhier cites a case of an idiot in whose intestines one thousand were found. Dr. Condie has known as many as a hundred and twenty to be voided in a single day by a child five years old. Dr. Meigs says: "I have never myself known more than six, eight, or ten to be expelled within a few days' time, and very generally there have not been more than three, four, or five." Hensch states that he remembers a case in which whole vesselsful of round worms were passed for a number of days in succession. Bartholow says there may be one, two, or three worms, or they may reach five hundred or a thousand.

### OBSTETRICS.

#### Statistics of Symphysiotomy.

Dr. ROBERT P. HARRIS publishes (*American Journal of the Medical Sciences*) a careful analysis of the statistics of symphysiotomy, with comparative tables of the earlier and later cases, showing that the operation has been more frequently performed in Italy in the last seventeen years than in the previous eighty. In his first table, extending up to 1858, out of 70 cases there was a maternal mortality of 70 per cent. and a foetal mortality of 67 per cent. The second table begins with the resuscitation of this operation in Naples in 1866, and as far as he has been able to learn, there have been 53 operations in that city, saving 43 women and 42 children. From a report of Prof. Morisani, by whom most of these operations were performed, we learn that—1. All of the fifty operations (in table 2) were performed upon rachitic subjects, whose pelvis were generally flattened antero-posteriorly. In four or five instances the pelvis were simply dwarfed in dimensions. There was no case of rostrate pelvis, as malacosteon is very rarely met with

in Naples. 2. Version was not resorted to except in the transverse positions. The forceps were applied in about one-fourth of the cases. 3. The separation at the pubes amounted to about 2 inches (50 mm.), which was attained without any effort, and without producing any lesion of the sacro-iliac synchondroses. 4. The immovable dressing secured the firm union of the symphysis pubis in all the cases that recovered. 5. The women had good health after the operation. 6. There were no malformed infants. Nearly all of the children were sent to the Foundling Hospital to be taken care of. 7. Phlegmasia alba dolens did not occur in any of the women. 8. There were no pelvic lesions left, as a sequel of the operation, with the exception of one case of iliac phlegmon. 9. Vesico-vaginal fistula occurred in but one case, and this was easily cured by an operation.—*Ibid.*

#### The Straight-Bodied Position in Labor.

In the *British Medical Journal* Dr. A. DRUMMOND McDONALD appears in an article entitled "The Straight-bodied Position in Labor." He desires to corroborate an observation by Dr. G. Hurt, of this country, that a sharply-flexed and abducted position of the thighs conduces to perineal injury, although he does not believe, with Dr. Hurt, that this position relaxes the perineum, but only that no artificial pressure is put upon it. "In every case where the presenting mass has almost reached the perineum," he says, "the patient should be placed in the straight-bodied position; that is, with the lower extremities adducted, and in the same straight line with the body. The effect of this position is to retain the natural obtuseness of the angle of inclination of the perineal plane; it straightens the vaginal parts of the passages and prevents the sacral segment of

the floor being converted into a valvular lid for the pelvic box in its coccygeo-pubic plane. Hence, a demonstrable source of speedier labor." He cites 18 cases—19 children, there being one twin labor. There were ten primiparæ, three secundiparæ and five multiparæ. Eleven mothers were delivered by forceps. The results are as follows: Fourteen cases afforded positive proof in favor of the straight-bodied position; two gave negative proof in its favor, and two tended to prove that straight-body *plus* support exercises only a slight beneficial influence, where there is genuine rigidity of the perineum, though it is probable that the flexed thigh position *plus* support would have produced a worse result. He believes that the other methods for acceleration of delivery and prevention of laceration find a valuable adjunct in the straight-bodied, or, as he proposes to call it, the *orthoclematic position*.

#### Parturition in Primiparæ of Advanced Years.

MANGIAGALLI has advanced the opinion that the difficult labors usually observed in primiparæ of advanced years are due to some physical defect independent of the age of the patient. The women are deformed, and on this account marry late in life; but had they married earlier the same difficulties in parturition would have been encountered. In order to test this theory Dr. Rumpe has examined the records of one hundred primiparæ, over thirty years of age, at the Marburg Clinic. His investigations led him to reject Mangiagalli's views. He concludes that the difficult child-birth in such cases is due to two causes—sluggish pains and rigidity of the soft parts. Another cause he finds in the relative frequency of male births in these cases. Out of the one hundred mothers eight died. The mortality

among the children was also greater than in the first labors of younger women.—*Archiv. fur Gynäkologie*.

#### To Relax a Rigid Os.

Dr. BOARDMAN REED (*Medical and Surgical Reporter*), calls attention to the danger of causing rigidity of the os by the employment of ergot during the first stage of labor, the physiological action of the drug being to contract the circular muscular fibres in the os more than those in the fundus. When rigidity exists independently of ergot, he finds the exhibition of opium and chloral hydrate, internally, or morphia and atropia, hypodermically, to be par excellence the agents for its relief. He gives preference to the combination of morphia and atropia, hypodermically: He fails to give the quantities or proportion of these alkaloids, but we presume he refers to their salt (the sulphate) and the usual proportion (one part atropia to twenty of morphia), and would inject, say, morphiæ sulph., gr. 1-6, and atropiæ sulph., gr. 1-120. Writers for the general profession should be definite in their statements in such matters.—*Med. Herald*.

#### Hydatidiform Disease of the Chorion.

Dr. STEPHENS writes to the *British Medical Journal* as follows: On September 7th, I was sent for by a midwife to attend Mrs. C—, who was flooding. On my arrival the hemorrhage had stopped. On making an examination the uterine sheath was not sufficiently dilated to be able to ascertain its contents. On passing my hand over the abdomen, I remarked to the midwife how unusually circular it was. On the following afternoon I was again hastily summoned, and found the woman had lost much blood. On making an exam-

ination, I found that, by a little manoeuvring, I could insert my hand into the uterus; and I vividly remember how astonished the midwife and Mrs. C—— looked, when I informed them that it contained no child. In fact, the patient stoutly declared that she had felt the child many times; and that, being the mother of thirteen children, all living, she ought not to have been mistaken. After administering a full dose of ergot, some sharp uterine pains followed, soon expelling a mass, which, when collected, filled three ordinary sized chamber utensils. After this jelly-like mass had been expelled, she made an uninterrupted recovery.—*Med Record.*

#### Treatment of Puerperal Sepsis.

Too lavish irrigation of the uterine cavity is to be avoided. In Prague the mortality in 1879 was: 0.4 p. c.; 1880, 1.0 p. c.; 1881, 0.21 p. c.; 1882, 0 p. c. The mortality of 1880 was ascribed in a great degree to the profuse intra-uterine irrigations. More, by far, can be accomplished by strict attention to the ulcers on the genitals, as the infection in most all cases goes out from them. As a wash for the vagina hypermanganate of potassium, or tincture of iodine may be used with good results. After this has been tried and avails nothing, then it is time to proceed to irrigation of the uterine cavity with a five per cent. phenol solution. Permanent or repeated irrigation is not only useless but dangerous; a single thorough toilette of the cavity is all sufficient. Many interesting cases illustrate the text—*Ibid.*

#### Pregnancy Nephritis

Is a disease of such rare occurrence that, according to Dr. REGINALD SOUTHEY (*London Lancet*), a physician may follow his profession for years

without meeting with a case. It is a disease, he says, unaccompanied by any symptoms attracting serious attention, until its presence is made known by rapid anasarca, sudden convulsion, uræmia, or cerebral disturbance. He divides the nephritis of pregnancy into three varieties, differing in their symptoms, causes and issue. The distinction in their prognosis he regards as very important. These varieties are: Eclampsia parturientium, a succession of epileptic convulsions happening at the time of labor; chronic Bright's disease complicated with pregnancy and becoming more dangerous while that condition lasts; and pregnancy nephritis proper, which, he says, is a cortical, glandular nephritis, an acute change in the nutrition of the epithelium of the kidney, and which may occur in the third month, but more frequently in the sixth, and which may be accompanied by all the symptoms of the other varieties, and sometimes even by death, but which usually ends suddenly with miscarriage and entire recovery. As to the etiology of the disease, he says, it may possibly be due to pressure on the neck of the bladder, whereby increased pressure of the urine in ureters, the pelvis of the kidney and tubuli uriniferi is produced, and in favor of that view are the following facts: That it occurs usually only in the latter months of pregnancy; that primiparæ are more liable to it than multiparæ; that it is almost peculiar to twin pregnancies; and that the anasarca and albuminuria quickly pass off. He does not believe that any lasting injury is done to the kidney, but that it is, at the beginning, a functional trouble principally. The prognosis is good for first pregnancies, but after that the nephritis lasts a longer time with each pregnancy, and after delivery is more likely to pass into the chronic form. In pregnancy

nephritis, he says premature labor should be brought on as soon as possible.—*Weekly Med. Review.*

#### Vomiting of Pregnancy.

One-fortieth of a grain of podophyllin and 1-200 of a grain of atropin will often check and cure the vomiting of pregnancy when other things fail.—*Med. Brief.*

#### Galactagogue.

Ergot has been used to check the excessive flow of milk. One of the best remedies to promote the flow of milk is said to be jaborandi, or its alkaloid, pilocarpine.

#### The Breaking Strain of the Umbilical Cord.

Dr. NEVILLE, in a paper read before the Academy of Medicine in Ireland (*Medical Press and Circular*) gives the result of 125 experiments performed by him with a view to ascertaining the amount of traction the funis would bear:

In 100 cords from which the blood had been allowed in great part to escape before subjecting them to strain, the average tensile strength amounted to 12.5 lbs.; one cord bore a strain of 27 lbs.; nine cords a strain varying from 20 to 25 lbs.; eighteen of from 15 to 20 lbs.; forty-eight of from 10 to 15 lbs.; twenty-three of from 5 to 10 lbs.; and one of less than 5 lbs. In the case of 25 cords tested without allowing any escape of the blood contained in them, the average breaking strain was found to be very little over 11 lbs., or nearly one and a half pounds less than in the other case. The cords belonging to male were found to have an average strength of 1.5 more than those of female children: multiparity made no appreciable difference in strength. The strain

was always gradually increased until the cord broke; and rupture was most commonly found to be first marked on the outer aspect of the cord where an umbilical vein projected in a varicose manner. Thin, straight, and wiry cords, possessing a comparatively small amount of Whartonian jelly, and whose surfaces were at least marked by varicose projections, habitually bore the greatest strains. The rather scanty literature on the subject was summarized; especially a paper by Pfannkuch (A. f. G. Band VII., Heft 1), who studied the effects of a sudden strain caused by the falling of the child's body, if delivered when the woman was in the upright position. Dr. Neville considered the question of a gradual drag as affecting inversion of the uterus. Assuming as conditions a strong funis abutting at or near the centre of the fundus on a firmly adherent placenta, and a flaccid pliable uterus, wanting in contraction and retraction, he thought improper tractions on the cord very likely to terminate in inversion. Inversion is a rare accident, because these conditions are rarely met with in combination, and because real fundal attachment of the placenta is particularly uncommon, notwithstanding text-book statements to the contrary.—*Med. Age.*

#### Treatment of Placenta Previa.

Supported by an experience of forty-six cases of placenta previa, HOFMEIER advocates early interference. As soon as pains begin, to resort to version, according to the method of Braxton Hicks, and not lose time with the tampon, which latter does not always stop the hæmorrhage and further increases the danger of infection. In case of placenta previa centralis, where the cervix still remains and the os externum is narrow, the author advises, in the event of

profuse hæmorrhage, the perforation of the placenta and an attempt at delivery of one foot. During extraction, which must necessarily be very slow, ergot is administered. Post partum, the uterus must be washed out with a five per cent. solution acid. carbol. His results are good. In forty-six cases he counts only five deaths.—*Zeitschr. f. Geo. and Gyn.*, viii., p. 89.—*Ibid.*

#### Bacteria and Puerperal Septicæmia.

Many investigators have been engaged in this field of pathology without having as yet given us any accurate data. The latest researches in this direction have been made by Dr. FERDINAND KAREWSKI, of Berlin. He has found bacteria in the lochia of the healthy as well as of the sick, and the *Medical Times and Gazette* notes his conclusions as follows :

He supposes that they are derived from the atmosphere; that they get into the vagina when this canal is opened up during parturition; and he points out that the conditions within the vagina as to warmth and moisture are highly favorable to the life, growth and propagation of organic forms, and that under such circumstances they may, so to speak, cultivate themselves, and change under cultivation, till an exceedingly virulent bacterium is the result. If we admit that such is the case, it explains why some lochia should be more dangerous than others, and why the later lochia should be more obnoxious than the earlier.—*Med. and Surg. Reporter.*

#### Pregnancy Complicated with Cancer of the Cervix.

Dr. EDIS related to the Obstetrical Society of London (*Medical Times and Gazette*) the case of a woman six months pregnant, who eleven months previously

had begun to suffer from pain, hæmorrhage and discharge. There was epithelioma, involving the whole circumference of the cervix and the greater part of the posterior vaginal wall. Palliative treatment was adopted. When labor commenced it was evident that delivery *per vias naturales* was impossible, so Cæsarian section was performed. The child was born in a state of suspended animation, but recovered; the mother also recovered, and when seen, eight months later, the disease had made but little progress.—*Ibid.*

#### Abdominal Presentation.

Dr. MARCHIONNESCHI reports one case and refers to three others in the *London Medical Record*. The dorsum was lying upwards, the abdomen underneath, masked by the agglomerated upper and lower extremities. He reached down a leg and found the umbilical cord so tightly twisted around it that it was difficult to pass a pair of scissors to divide the cord before bringing down another leg. The rest of the child followed easily and it was born alive, healthy and well shaped. All progressed favorably.—*Ibid.*

#### Venesection to Prevent Premature Birth.

Dr. MAYO writes to the *Australasian Medical Gazette* to the effect that he has found phlebotomy an efficient preventive of premature births. He recommends that from three to four ounces of blood be extracted soon after the first indication of quickening. For fifty years he has resorted to this practice with good success. And he adds that he bleeds indiscriminately both robust and delicate women.

## DISEASES OF WOMEN.

## The Treatment of Chronic Uterine Affections.

Dr. L. CH. BOISLINIERE (*St. Louis Courier of Medicine*), in a paper read before the St. Louis Obstetrical Society, February 15, 1883, says: The proposition that it is intended to maintain in this paper is that in chronic affections of the uterus most frequently the disease is primarily in the organism, and the lesion secondarily at the uterus, although it must be admitted that in a limited number of cases the lesion may be primarily at the uterus, and the disease, through sympathetic irradiations, may be secondarily in the organism.

I therefore exclude from this study all the acute, all the surgical diseases of the uterus, all its traumatisms—such as laceration of the cervix and perineum, the fistulæ, etc., and all the tumors and neoplasms, although some of the latter may occasionally be benefitted and even cured by agents affecting the condition of the blood and its distribution to the uterus.

In the surgical diseases of the uterus we must all admit that active interference is very often imperatively demanded. Whilst yielding to this legitimate demand, I may express the hope that greater moderation and more deliberation may be exercised in deciding upon and selecting the best procedures, and also that greater fairness may be displayed by operators in relating failures as well as successes. In this matter, if all the operators would have the fairness displayed by Dr. G. J. Engelmann, who has reported his failures as well as his successes, we would have a more reliable basis on which to establish a comparison between the results obtained respectively by the medi-

cal and surgical treatment of uterine affections.

I believe that, unless we admit the importance of constitutional influences in the causation and maintenance of many local lesions, a permanent cure of these lesions will not be obtained. Galen has said: "*Est uterus affectus ita ut corpus.*" The uterus is affected like the body.

However, I would not be understood to say that no local treatment should ever be resorted to. The lesions, when once established, should be properly treated by local means. These lesions are often a source of irritation, and often a drain which adds to the patient's losses, and by a morbid solidarity react on the economy, especially if there be chlorosis present. This will be increased, for chlorosis will often create more chlorosis.

The local lesion should therefore be treated, and a temporary relief only will be obtained in all the cases where the lesion is not primarily at the uterus. In the very rare cases where it is primary I admit that the lesion may be permanently cured by topical means exclusively. But I reassert that when the cause is general, relapses will be the rule, and that no permanent relief will be obtained until the morbid conditions of the blood have been corrected. Then will often the local lesions disappear spontaneously, or with very little topical treatment.

I can no more look on inflammation of the os and cervix uteri as a primary disease, causing derangement of the general health, chlorosis, gastralgia, neuralgia, etc., than I can look on a gouty toe, a rheumatic knee-joint or an enlarged strumous gland as the primary diseases causing rheumatic fever, scrofula, etc. Such was also the opinion of Rigby.

To illustrate my position I take the case of a patient with syphilitic iritis. He falls into the hands of a narrow-minded specialist, who treats him by local applications only. Neither instillations of atropia in the eye nor any other topical application will ever cure this form of iritis until the patient, in the hands of a man with broader pathological views, shall be placed under the influence of mercury and iodine. Then the cure will be rapid and permanent. The instillation of atropia in the eye will, however, be continued, not with the view of obtaining a cure of the disease, but in order to remedy one of its worst consequences—permanent adhesions of the iris.

There are cases of strumous ophthalmia or otitis, of scrofulous naso-pharyngeal catarrh which no exclusively local applications will benefit. These cases will rapidly improve with cod-liver oil, iodine, iron and hygienic measures after topical treatment has been discontinued.

It may be asked, What are the chief general causes upon which depend functional and structural changes in the uterus? These causes are mainly alterations in the quality and quantity of the blood supplying the uterus and its appendages, and also the morbid diatheses giving certain specific characters to the blood.

One of the most frequent expressions of an alteration in the normal condition of the blood is chlorosis. The influence of this alteration of the blood on the nervous system will explain the production of local lesions, such as ulceration and catarrh of the uterus. Chlorosis acts in diminishing the innervation of the uterine system, perverts its secretions and from a morbid functional disturbance leads to a phlegmasia of the mucous membrane. Andral states that whenever the principal agents of life,

namely, the blood and the nervous system, no longer nourish and stimulate the organs in a healthy manner, the vital force of aggregation which unites the different molecules of the living tissues loses its physiological intensity, hence follows diminished cohesion of those tissues, and their softening.

The above views give, it appears to me, a true explanation of how ulcerations of the cervix, chronic endometritis and uterine catarrh are produced, and explains also the frequent formation of peri-uterine phlegmons and cellulitis as a complication of chlorosis.

Claude Bernard, in his well-known experiments on the section of the great sympathetic nerve, has demonstrated the effects of a perturbation of vascular innervation in producing congestion, phlegmasia and suppuration. This perturbation is the source of the menorrhagia, much oftener the result of chlorosis than of true plethora.

Hence the great importance of correcting by therapeutic means the chlorosis, which, if not corrected, will perpetuate the local lesions and the tendency to continually renewing menorrhagia. Local means, in this condition, will prove quite unequal to the task of curing the local lesions.

Chlorotic patients present a variety of indefinite neuralgic pains. These pains are not always an expression of local lesions, because they greatly vary in their location. In these cases it may well be said that pain is "the prayer of the nerves for healthy blood," as expressed so beautifully by Romberg.

Listen to that prayer, grant the request of the nerves by supplying them with healthy blood, and the neuralgia, the cardialgia, the hemicrania, the hysterio-epilepsy and the numberless ovarian pains will vanish in proportion as the blood grows richer, and harmony

will then be restored to the generative sphere.

Next in frequency to chlorosis are the different diatheses in producing chronic affections of the uterus.

The most important of these is the strumous or scrofulous diathesis. This condition begins early, and is the cause of the rebellious leucorrhœa, so often itself the origin of sympathetic chlorosis. The lesions produced by this diathesis, at first limited to the follicles of the cervix, as first shown by Morgagni, gradually gain the parenchyma of the organ, which subsequently becomes hypertrophied and hyperplastic.

At other times erosions and granular ulcerations become manifest, and are producing more or less discharges, which, under various circumstances, becoming suppressed, are replaced by inflammatory exudations about the broad ligament and the ovaries. Pelvic cellulitis is a frequent complication in the chain of morbid changes produced by the strumous diathesis.

The indications are, therefore, to correct this morbid element in order to obtain a permanent cure of the local lesions. A purely local treatment will never remove the lesions resulting from the influence of a strumous diathesis.

The same may be said of the influence of the herpetic, the tubercular, scorbutic or hemorrhagic, and especially of the syphilitic diatheses. Each should be met with the treatment best adapted to its nature.

Much importance in these cases should be attached to hygienic measures—to hydro-therapeutics, to the massage, to change of air and climate, and great attention to dietetics. Under these influences, the cardialgia, the nervous palpitations, the meteorism, the hysteric symptoms, the hysteric-neuroses, so

common an escort to chlorosis, will be much mitigated and finally cease.

Lastly, I must consider the alterations in the quantity of blood supplying the uterus and its neighboring organs as an important factor in the causation of chronic uterine affections.

Subinvolution is one of the most frequent pathological conditions which can be referred to that increased blood stasis, and predisposes to hypertrophy and subsequent areolar hyperplasia—the so-called chronic metritis. Dr. T. Gâilllard Thomas, in his admirable "Treatise on the Diseases of Women," remarks that this condition explains the fact that "so large a number of women with uterine affections refer their illness to child-bearing, and that so many who were well until that process remain invalid afterwards. These hyperplastic and subinvolved uteri were those which chiefly furnished Lisfranc's cases of 'engorgement,' which hundreds to-day are treating with powerful caustics as parenchymatous metritis."

The source of the evil is an excessive supply of blood to the organ, and until this is diminished all local interference by leeches, scarification and blisters will only palliate the condition until a thoroughly depletory plan of treatment is adopted, consisting chiefly of those agents considered most active in removing the passive congestion of the portal circulation, such as mercurial and saline purgatives, followed by iodine and arsenic.

Local depletion will have been of temporary service in these cases, but there will be relapses if no general treatment has been persevered in for some time.

An opposite condition to subinvolution is super-involution or uterine atrophy, supervening during the child-bearing period. This subject has been lately very well treated by Dr. W. Coles, whose

paper on this subject is full of suggestions.

Super-involution will not entail great uterine suffering, but is accompanied by very peculiar nervous symptoms, which should be treated, as well as the more or less complete amenorrhea which follows it. The permanganate of soda or potash, general tonics, and especially electricity applied to the interior of the womb, may remove or correct this condition. Electricity seems to stimulate growth. An infantile uterus, under the above agencies, will grow to the size of a normal uterus—a very curious fact and well ascertained.

The abnormal supply of blood above noticed may reach the ovaries, producing a state of venosity, or rather varicosity of the ovarian or pampiniform plexus, which, when excessive, may rupture, or, by a process of stillicidium, pour blood into the retro-uterine space and form a pelvic hematocoele, usually in Douglass' cul-de-sac.

It is only by the removal of this venous stasis that the danger can be averted. We should advise here a combination of local and general depletion, and especially frequent large doses of bromide potassium. The ovarian dysmenorrhea, a frequent complication of chronic ovaritis, will be thus relieved.

A singular symptom to be occasionally noticed in those cases of chronic ovaritis is what might be called seminal losses in the female, brought on without any provocation on her part and accompanied with marked orgasm. The patients will present partial or complete frigidity in the sexual act, and have no or only little desire for it. They will consult you for this frigidity, and make to you the above revelation. Of course, this emission is furnished by the vulvovaginal glands, so active in coition and parturition, and is the cause of the

greatest annoyance and debility in the patient, as the discharge and the orgasm are repeated several nights in succession, and may take place even during the day, in the waking state and without desire or co-operation on the part of the patient. I consider this condition a very grave one, as it may lead to epilepsy and insanity.

For the relief of it I have found the greatest benefit in repeated doses of the iodide of mercury and large doses of the bromide of potassium. No local treatment can be suggested for this condition except blisters in the iliac fossa, dressed with mercurial ointment; also measures which deplete the portal circulation and its tributaries, hydrotherapeutics, massage, etc.

Frigidity, another phase of ovarian functional disturbance, is the normal condition of all women suffering with chronic uterine affections. Frigidity to a more or less degree is also quite frequently met in women apparently healthy. The truth is that a majority of women have no strong sexual desire unless under great solicitation. A passionate woman is the exception. But when the frigidity is absolute, it suggests great ovarian atony, and should be remedied by general tonic and hygienic measures.

These patients should be advised to carefully conceal the fact of their frigidity from their husbands, because sooner or later it will lead to an alienation of conjugal affections. The husband will be tempted to look elsewhere for more fervid embraces. These women should pretend to receive the pleasure which they do not feel. Woman is affectionate, tender, devoted, but not, as a rule, sexually passionate as man or sensational novel writers, without ground, suppose. Man is the active, creating, woman the passive, nourishing principle.

Hence sexual excesses debilitate the man, not the woman. He who gives loses more than she who receives. "*Plus est in dando quam in accipiendo*," as the old school of Salerno has it.

In ending, allow me to say a word of caution in speaking of the prognosis to be expressed in all cases of chronic uterine affections. The prognosis should be very guarded, avoiding all flattering promises of a speedy cure. Call time into consultation, remembering that chronic diseases require chronic remedies.

Too encouraging promises should not be offered, especially for the cure of sterility, as this condition is very seldom cured after it has lasted more than five or six years.

If it depends upon uterine flexion, section of the stenosis will sometimes remedy it. This section will, however, almost always, if well performed, cure the accompanying dysmenorrhea, but not always the sterility, as formerly fondly believed.

The chief cause of the sterility must be attributed to some constitutional condition (occasionally to atresia of the Fallopian tubes). The cure of it is chiefly to be sought for in general tonic and hygienic measures, electricity, etc.; also by curing the sterility of the husband, and by procuring for the patient another husband after the death of the first.

Allow me to end this paper by the following conclusions:

The late excessive tendency to specialize has led us to attach, in uterine affections, too great an importance to the lesions and not enough to the general condition.

2. The morbid influence of the constitution on the uterus should be considered first, and the reciprocal influence of the uterus on the organism should be considered as secondary.

3. The uterus does not lead an isolated life in the organism, but it is only a link in that harmonious chain constituted by all the organs, and if the action of that chain be disturbed there will be suffering in every organ constituting the chain. There will be suffering in the uterus, as well as in any other organ, but not more.

#### Uterine Dyspepsia.

In an article upon this subject in the *Praeger Medicinische Wochenschrift*, Dr. E. H. KISCH remarks upon the relationship existing in health between the stomach and the uterus. He states that while normally the reaction of the stomach becomes neutral in five to seven hours after a meal, during menstruation it remains constantly acid. Not all affections of the female sexual organs give rise to dyspepsia, but only those of the uterus itself, and of these may be excluded all superficial erosions and affections of the mucous membrane, thus leaving as causes only the structural changes of the organ, versions, flexions, subinvolution, deep follicular and cancerous ulcerations, and similar conditions. The most frequent cause of digestive disturbance he finds to be retroflexion. The symptoms vary much in intensity, sometimes, however, they assume a most threatening severity. The appetite is capricious, the tongue is but slightly coated. There is often pain in the epigastrium, with sour eructations and heartburn. Sometimes there is vomiting after each meal, together with constipation and flatulence.

Sympathetic disturbances are common, such as palpitation of the heart, neuralgia, melancholia, etc. The affection is to be distinguished from gastric catarrh, ulcer of the stomach, and simple nervous dyspepsia. This is to be deter-

mined by attention to the symptoms peculiar to each of these conditions, but especially, and sometimes only, by the results of treatment. With the improvement in the affection of the uterus the dyspeptic symptoms subside. Hence all curative efforts are to be directed especially against the abnormal condition of the uterus. Certain mineral waters are often of great value, especially those containing sulphate of sodium. The author concludes by urging the necessity of a uterine examination in all cases of obstinate dyspepsia occurring in females.—*Med. Record.*

#### Menstruation an Abnormality.

Was the view advocated by Dr. C. A. DEVENDORF in a paper read before the Wayne Co. (Mich.) Medical Society. He criticises the structure of the human body as unadapted to the purposes for which it is intended, or rather he thinks that the erect posture which man alone assumes is inappropriate for a being so constructed. He argues that the monthly loss of blood by the human female is so contrary to the condition found in the lower animals, and is so far without apparent purpose or object, that it must be abnormal and injurious. In seeking an explanation of the phenomenon, he argues again from analogy that as the animals which go on all fours have no sanguineous menstruation, therefore it must be that the erect posture is the occasion of this discharge in the human female. Hence, he concludes that the assuming of the erect posture is a comparatively recent thing, and that the organization has not yet adapted itself to this posture. He calls attention also to the influence of the erect posture in the production of hernia and hemorrhoids, and believes that this is responsible also for the fierce and cruel

lust which makes a vicious man more vile than a beast.—*Weekly Med. Review.*

[By such bold speculations we may find some truth. A more advanced evolution may dispose of menstruation and demonstrate the truth of this theory. Unfortunately we will not live to see it.]

A. J. C. S.

#### Case of So-Called Imperforate Hymen.

A paper on this subject, by Dr. MATTHEWS DUNCAN, was read before the Obstetrical Society of London. He was induced to relate the case by three circumstances :

1. There was a remarkable absence of any kind of suffering during nearly the whole time of the development of the disease. The patient had never menstruated, nor suffered from any uneasiness in connection with that function, until about eight months before admission, when she was told by a medical man that she had a lump in the lower belly. Since then she had suffered from irregular aching. The author thought that the probable explanation of this was that the uterine body was not distended, for facts showed that dilatation of the uterine body was more difficult and painful than dilatation of the vagina and uterine cervix.

2. The case illustrated the treatment without any injections, which had been the subject of remarks at a recent meeting of the society. An incision was made by Paquelin's cautery knife. About twenty-five ounces of the usual treacly fluid escaped; about twenty ounces on the following day, and the last of it on the fifth day; in all about fifty ounces. At no time had it any fetor. No hypogastric pressure or interference with the flow was permitted. A piece of carbolized lint was put to the vulva. The patient made an uninter-

rupted recovery. He thought the risk of peritonitis was increased by the washing out sometimes practiced. He thought the cautery knife was preferable to any other mode of making the incision, because its wound was not an absorbing surface.

The condition of the pudendum rendered the term "imperforate hymen" erroneous and misleading. The vagina was closed by the membrane, upon which the hymen could be seen, entire and healthy; and after the operation the hymen could be seen to have its normal position and relations. He had made the same observations in other cases, and he had seen the hymen present when vagina and uterus were both absent. On these grounds, he regarded the view of M. Budin (that the hymen was nothing but the anterior extremity of the vagina) as incorrect. Dr. Robert Barnes said that, in these cases, toxemia arose before the blood was evacuated, from decomposition of the hemato-globulin in the retained fluid. He had not used injections; they were not called for in all cases. Dr. Gervis could hardly accept Dr. Duncan's views that the membrane occupying the area within the hymen was the vaginal wall. He thought the variations in shape of the hymen and the absence of muscular fibres in it militated against M. Budin's view. Dr. Carter had had under his care a case similar to that described by Dr. Gervis. He had divided the septum, and the patient did well. He thought washing out was meddlesome, unless the discharge were offensive or there were symptoms of septicemia. Dr. Rodgers mentions a case under his own care. Some pyrexia followed the operation. The vagina was not washed out till a week after the operation, and when this had been done the pyrexia subsided. Dr. Galabin thought it an important

question whether, in these cases, it was desirable to use injections immediately, after an interval, or not at all. The danger was greater the higher the atresia was situated. He had known of two cases of high obstruction, in which death had followed evacuation, although no syringing was used. Emmet had published a number of cases, many of them atresia high up, in which recovery had followed treatment by injections. He (Dr. Galabin) generally let the fluid flow for twenty-four hours, and then began antiseptic injections. All his cases so treated had been successful. Perhaps it would be best if a perfectly aseptic condition could be maintained by antiseptic dressings. The President said that Dohrn had entered elaborately into the developmental histories of vaginal closures. What he (Dr. Duncan) wished to show was that cases with blue thin-walled bulging between the labia were generally, often erroneously called imperforate hymen; whereas in many, and also in cases where there was no vagina, a hymen could be distinctly seen.—*British Medical Journal.—Obstet. Gazette.*

#### A New Uterine Repositor.

Flexions and versions of the womb often cause the patient great suffering, and even our best gynecologists have not always found the means of cure unattended with difficulty, if not danger. In these ailments two things are required. The womb should be replaced in a normal position, and when thus *in situ*, retained.

The instruments used as repositors have been the ordinary sound or some instruments with a straight shaft, both of which are difficult to use without abrading the endometrium or causing a good deal of pain. The sound, rotating on its axis, carries the fundus through

the arc of quite a large circle ; considerable force is often required, and there is a possibility of swinging the womb into a wrong anatomical position as regards its ligamentous supports. An abrasion of the endometrium, corresponding to the arc through which the sound-tip passes, is likely to result. The jointed or hinged repositors are very difficult to introduce, unless the os be dilated, but less injury to the endometrium will be done while the womb is being replaced.

To obviate these difficulties and dangers this new repositor has been devised. It consists of a probe-pointed shaft, similar to an ordinary sound, the portion near the point being flexible and easily curved as desired by turning a thumb-screw at the handle, the instrument furnishing its own fulcrum within the shaft. The extent and direction of the curvature is shown by an indicator attached to the handle. When the instrument is straight the indicator is parallel with the shaft, but when curved by turning the thumb-screw it is deflected in the direction of the curvation.

Some of the advantages claimed for this repositor are : 1. Ease of introduction. The instrument, like the flexible probe, may be curved to suit circumstances, and so introduced into the uterus, whatever its malposition. 2. The direction and extent of curvature is always indicated. 3. The lateral movement of the fundus is avoided. 4. The injury to the endometrium is reduced to the minimum, for the point of intra-uterine portion moves upwards and downwards, as desired, by turning the thumb-screw, which produces a movement somewhat similar to that of the index finger when being flexed upon the palm of the hand, except the range is greater—being on both sides of the axis. 5. The index shows you, at all

times, the amount of contraversion that you are producing, when you are replacing the uterus from its abnormal position. 6. It may be quite safely used to break up any slight adhesions that may be formed between the uterus and other portions of the pelvic viscera, when in its malposition. 7. Also to overcome, by somewhat forcible distention, the rigid and somewhat atrophied uterine fibres that tend to keep the uterus bent upon its long axis, thus improving the nutrition at the seat of flexion.

From an extensive trial of this repositor—for I have used it successfully in nearly one hundred cases, embracing all varieties of uterine flexion and version, in the married and unmarried—it is believed the profession will find this new instrument worthy of a prominent position in their gynecological case.—C. HENRI LEONARD, A. M., M. D., in *Leonard's Illustrated Medical Journal*.—*Ibid.*

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## DISEASES OF CHILDREN.

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### Whooping-Cough.

At the last meeting of the Medical Society of London, Mr. DOLAN read an abstract of a paper on the pathology and treatment of whooping-cough, for which he had received the Fothergillian gold medal of this Society. Dealing with some points of pathogeny, he expressed his dissent from the view of Guéneau de Mussy, that the malady was a bronchial adenopathy, its chief symptom being induced by pressure on the vagus by the enlarged glands, and showed that this glandular enlargement was not always present in pertussis ; and, further, that the glands may be swollen without producing the characteristic cough. The disease, indeed, bore much resemblance

to those diseases the causes of which are now believed to be minute organisms or fungi. Its highly contagious nature, period of incubation, effervescence and defervescence, its regular course, and the immunity from subsequent attacks, were grounds of analogy determining the place of pertussis in the group of diseases caused by protophytic fungi. The attempt by Linnæus to prove that all diseases were produced by animalcula, or had an insect origin, foreshadowed the conclusions now arrived at by the discoveries of Pasteur. In 1867 Poulet found bacteria in the sputa of pertussoid patients, and Letzerich had induced whooping-cough in rabbits by inoculating the trachea with sputa from the human subject.

The author had repeated these experiments, and found that whilst inoculation with the blood of whooping-cough patients was without effect, that of sputa and other secretions caused death. He had found also, on microscopic examination of sputa, ordinary bacteroid forms and a microbe resembling the *Spirochæta plicatis* of Cohn. The application of special methods of staining, as employed in the detection of the *Bacillus tuberculosis*, would no doubt reveal the special microbe of pertussis. Admitting the fungoid nature of pertussis, its contagious property was easily explained by germs being thrown off into the air and received into the body, setting up constitutional disturbance, and subsequently attacking the pulmonary epithelium, giving rise to all the phenomena of pertussis. No pathognomic lesions could be detected on post-mortem examination, for the simple reason that whooping-cough was rarely fatal. Death resulted from complications which were very numerous. As to glycosuria in whooping-cough, he had found it present in fourteen out of fifty cases.

Turning to the question of treatment, he pointed out the necessity for measures of isolation in preventing the spread of the disease, for the enforcement of which measures the co-operation of all classes of the community was needed; and, although the course of the disease could not be controlled by treatment, the patient could be placed in the most favorable circumstances towards recovery; certain painful and prominent sources of trouble could be relieved, and complications guarded against, so as to assist nature in her efforts to throw off the disease. There is no panacea or specific remedy; but if the dependence of whooping-cough upon a specific virus be the true explanation of its pathogeny, the lines on which its rational treatment and prophylaxis are to be pursued become clearer and more hopeful.—*Canadian Practitioner*.

#### Whooping-Cough Remedies.

M. PIERRE VIGIER, in a French journal, gives a few prescriptions. First he recommends Drosera to be given in the form of alcoholate for a child one to two years of age, 20 drops three or four times a day in a little sweetened water; for older children, from one to four teaspoonfuls in the course of the day. The favorite remedy of Dr. Delpech is one frequently employed in this country, namely, 30 grains of powdered cochineal and 20 grains of subcarbonate of potash in half a pint of water, flavored and sweetened. M. Vigier gives as a modification of this formula a recipe for a preparation which will keep, as follows: Powdered cochineal, 15 grams; subcarbonate of potash, 12 grams; boiling water, 600 grams; sugar, 900 grams.

Infuse the substances for half an hour, add the sugar, dissolve with a gentle heat, and strain. Children of one

to two years may take two to three teaspoonfuls per day; older children from three to six teaspoonfuls; and adults two tablespoonfuls per day.

Dr. Beauchene prescribes the following powder: Calcined magnesia, 8 grams; sugar, 2 grams; extract of belladonna, 20 centigrams; kermes, 10 centigrams; orris, 60 centigrams.

Mix the extract and the sugar, add the kermes and the orris, then the magnesia and triturate to homogeneity. Divide into fifty powders. Children of one year may take three per day between meals; children from two to three years of age, five; and older persons, eight.—*Can. Med. Record.*

#### Recurrence of Scarlatina within Eight Months.

F. P. KINNICUTT, M. D., in *N. Y. Med. Record*, says that he attended a male child aged five, in a typical attack of scarlet fever, having a favorable termination; eight months afterwards he was again called to the same child, and the diagnosis of scarlatina was again made: slight albuminuria made its appearance in the third week and still persists; patient has suffered with a number of boils on various parts of the body.

Dr. Kinnicutt remarks that a second infection of scarlet fever occurring within the short period of eight months, in which all the characteristic symptoms are manifested with as much prominence as in the primary attack, is sufficiently rare to be worthy of record. The doctor has only been able to find six other recorded cases of a similar nature; the shortest and longest period of recurrence were respectively thirty-six days and nine months.

The above case conflicts with the terse and generally accepted statements of the various text books, "one attack protects from a second."—*Ibid.*

#### The Treatment of Scarlatina

With remedies believed to have the power of destroying animal and vegetable organisms, is a plan that has been pursued with great differences of opinion as to the advantages derived. The benzoate of ammonia, said to be a germicide, is used by Mr. A. DRUMMOND MACDONALD (*British Medical Journal*) with happy effect, both in the milder and anginose forms of the disease. He gives it in doses of fifteen grains every three or four hours to adults, and proportionately to children, either alone or in combination with liquor ammonia acetatis.—*Weekly Med. Review.*

#### Intussusception in Infants.

Dr. W. R. GILLETTE, in the *New York Medical Journal*, states that he has succeeded in reducing three cases of intussusception in infants by the administration of chloroform, injections of warm water, and the application of massage to the mass felt through the abdominal walls. He knows of two other cases, where all the ordinary means failed, and reduction was effected by chloroform and massage. The children, in all these cases, were held, and the injections forced into them against all voluntary and involuntary efforts that they could make. In one case the gut had been invaginated forty hours, and in another for three days. In one case, the particulars of which are recorded, the water, after three or four bulbfuls were thrown in, was rejected. This was repeated constantly; it seemed almost impossible to get the gut to retain any water. Finally, an assistant resorted to massage (the infant being under chloroform). Immediately there was a roar of rushing wind and water, and a large amount of water passed in and was apparently retained. The child was laid down, warm

bottles put around it, to rally it after the ordeal; the bowels were moved in a short time and a rapid recovery ensued.—*Med. and Surg. Reporter.*

#### The Endermatic Use of Quinine.

Dr. GALANTI, of Rome (*Gaz. Med. di Roma*), uses an ointment of sulphate of quinine, applied to a blistered surface, in the malarial pneumonia of children.—*Ibid.*

#### Negative Effect of Vaccination on Fœtus.

In the *Maryland Medical Journal*, Dr. POWELL reports the case of a lady in the eighth month of pregnancy, whom he vaccinated successfully. Since her confinement her child has been vaccinated and has had a typical crust and scar, showing the absence of any protective influence from the mother's vaccination.—*Ibid.*

#### A Child Born with Teeth.

Dr. KOCHMAN of Strasburg relates the history of a primipara who gave birth at full term to a healthy child with the two lower internal incisors just beginning to protrude. These were out and well grown at the end of a week.—*Allgemeine Medicin Central Zeitunge*.—*Med. Record.*

#### Cotton Seed in Spasmodic Croup.

Dr. G. L. GRAY, in Mississippi Valley *Med. Monthly*, states that he has used this remedy successfully. Take a handful of seed, bruise them, boil in a quart of water for a few minutes, let it stand a short time, strain, sweeten, and when cool enough give the patient all he will drink, or, if necessary, pour it into the child. The relief is generally prompt, and sometimes without emesis. If persisted in, it produces free emesis. Dr. Gray also states that he has used the remedy with benefit in two cases of asthma.—*Ibid.*

#### A Cathartic for Infants.

Dr. J. COOPERIDER, Taylorsville, Indiana, sends in response to the request for a cathartic for infants the following, which he has found quite satisfactory in his practice:  $\mathcal{R}$  Ext. sennæ fluidi,  $\mathfrak{z}$  j.; sodii sulphatis,  $\mathfrak{z}$  ss.; spts. limonis,  $\mathfrak{z}$  j.; syrupi, q. s. ad,  $\mathfrak{z}$  iv. M. Sig.: A half teaspoonful to teaspoonful every two to four hours, according to age.

Dr. M. R. MORDEN, Adrian, Mich.: In answer to Dr. Postlewait, in regard to a suitable remedy for constipation in infancy, I wish to attest my confidence in the pulvis glycyrrhizæ compositus for the same. It consists of:  $\mathcal{R}$  Senna, liquorice (powder),  $\mathfrak{aa}$   $\mathfrak{z}$  vj.; fennel, sulphur,  $\mathfrak{aa}$   $\mathfrak{z}$  iij.; refined sugar,  $\mathfrak{z}$  xvij. May be given best in form of a thick tea, in one-quarter to one-half teaspoonful doses to infants, and to large children, aged persons and delicate adults in teaspoonful doses, once, twice, or thrice daily, as may be needed. After ten years' experience with its use I recommend it as being pleasant, safe and efficient. One dose at bed-time generally answers. I never knew of but one child that did not like it.

Dr. WM. R. SMITH, Sr., Cairo, Ill., writes: From my own experience this winter I think the constipation of the little patients, referred to by Dr. Postlewait, is caused by catarrh of the colon and rectum. Would advise him to give the following:  $\mathcal{R}$  Sodii phosphatis granulati,  $\mathfrak{z}$  ij.; Ft. chart., no. viij. Sig.: One powder in a tablespoonful of milk, three times daily.—*Med. Age.*

#### Surgical Treatment of Umbilical Hernia of Infants.

The treatment of this condition has not been very satisfactory, and only rarely has it been successful in keeping the children alive. Generally, in the

lighter grade of cases, the expectant treatment is pursued, and in graver cases the restoration of the viscera to the abdomen, and the application of antiseptic bandage so as to make compression. The ligature has been used to the neck of the sack, and it has at times been successful, but it has also been followed by a fatal result.

Krukenberg has reported a case in which the large hernial sac contained a part of the liver and colon; he restored the viscera, and, under rigid antiseptic precautions, opened the sac, dissected it out, and ligatured the edges with ten silk ligatures, only fourteen hours after birth. The wound was dressed antiseptically, with a compress and bandage, and complete recovery followed.—*Archiv. für Gynaekologie.—Med. Times.*

#### On the Treatment of Infantile Paralysis.

Dr. ROBERT J. LEE calls attention to the very marked value of artificial heat in the treatment of infantile paralysis. This he illustrates by the case of a girl suffering from this disease in a severe form, who received no other treatment than hot sponging night and morning, and artificial heat to the affected limb, after going to bed. This limb was equal in size to the sound one eight years after the attack came on, although still paralyzed below the knee.

Dr. Wm. H. Barlow refers to the fact that artificial heat is an old therapeutic method in the disease in question. He considers it always necessary to protect carefully the paralyzed limbs, but believes that electro-therapy and voluntary and passive movements are much superior remedies to heat.—*Journal of Nervous and Mental Disease.—Med. Record.*

#### Sulphurous Acid in the Treatment of Scarletina Maligna.

Dr. KEITH NORMAN MACDONALD makes a strong plea for the use of sul-

phurous acid in conjunction with the ordinary remedies in the treatment of malignant scarlatina. He is of the opinion that to be successful in most cases of scarlatina maligna the treatment must not only be promptly and vigorously, but also intelligently applied, and that when so carried out the worst cases need not be despaired of. His plan of treatment is as follows:

"The moment the throat begins to become affected I administer to a child of five or six years of age 10 minims of the sulphurous acid with a small quantity of glycerin in water every two hours, and I direct the sulphurous acid spray (strength 3 ij.-3 iv. to the ounce of water, according to circumstances) to be applied every three hours to the fauces—about twenty squeezes; and when that can't be done, to hold the instrument about six inches from the mouth, and use it for a few minutes at a time. The acid solution must be recently prepared, as, when it is kept for some time in water, it takes up an atom of oxygen and becomes sulphuric acid. It is of some importance to bear this in mind, as the efficiency of the acid treatment depends entirely upon its composition."

At the same time he administers a mixture containing from three to five grains of chlorate of potash with seven to ten minims of the tinct. ferri perchlor. in glycerin and water, more or less, according to age, every four hours. He further directs a strong solution of permanganate of potash (3 ij. or more to six ounces of water) to be held in readiness for laving the lips and mouth several times in the day to arrest the formation of the dark sordes which collect about these parts; some of it should be swallowed, if possible, each time the lotion is applied, gargling being out of the question in young children.

Sulphur should also be burned in the

sick-chamber, three times a day at least, by placing flour of sulphur upon red-hot cinders on a shovel and walking about the room with it, thus diffusing the sulphurous acid vapor through the apartment until the atmosphere becomes a little unpleasant to breathe. — *Med. Times.*

#### **Abscess Discharging at the Umbilicus in an Infant.**

In the *Boston Med. and Surg. Jour.*, February 1, 1883, Dr. C. W. STICKNEY reports the following case :

When first called to the case, in April last, I found the child suffering evidently from gastro-intestinal derangement, manifested by vomiting of everything taken into the stomach, slight febrile disturbance, thirst, sleeplessness, and constipation. There was some tympanites, but at first no tenderness of the abdomen. The tongue was covered for the most part with a thick, soft, white fur. The child had been troubled more or less with constipation from birth, otherwise had been healthy. Suspecting intestinal obstruction, I administered castor oil, which, however, affected the bowels naturally, thus relieving anxiety in this direction. After two or three days I found on palpation a circular area of induration about three inches in diameter, having the umbilicus as its centre. The umbilicus seemed to rest in a cup-shaped depression in the surface of the tumor; the swelling and induration were accurately defined by an abrupt though somewhat rounded circumference. Very light percussion revealed dullness over the affected region; deep percussion was tympanitic, like the rest of the abdomen. Hop-bags and cloths wrung out of hot water were applied to relieve discomfort. Soon, however, the umbilicus began to push forward as a rounded red tumor, which

soon showed distinct fluctuation. Suppuration being now certain, light poultices were applied, and on the sixth day the umbilical tumor ruptured and discharged a small quantity of healthy pus. Some relief of symptoms followed, but the circular tumor remained in the same condition. Poultices were continued in the hope of keeping up the discharge, so that eventually the abscess might thoroughly evacuate itself through the external opening, thus lessening the risk of rupture into the peritoneal cavity. Matters now progressed well; there was a constant free discharge of pus, and the indurated mass was perceptibly softening. But on the morning of the ninth day, while straining to evacuate the bowels, the patient passed suddenly into a state of collapse, and never rallied. An autopsy was not permitted.

When asked for a diagnosis, I gave : Either abscess of the abdominal wall external to the peritonæum, or localized suppurative peritonitis circumscribed by adhesions—death in either case being caused by rupture into the peritoneal cavity.—*Med. and Surg. Reporter.*

#### **A Case of Cerebro-Spinal Meningitis.**

On Saturday morning I was called in great haste to see a child four years of age. Upon my arrival I discovered the child in a spasm, and remembering that I had treated him on a former occasion for a convulsion due, as I considered, to malaria, I immediately ordered a tub to be brought in half-filled with warm water, to which was to be added about a tablespoonful of mustard. By the time the bath was ready, I expressed the opinion that it could be of no service whatever and had it removed without using it. Having been impressed with the peculiarity of the fit, I concluded it

was one of those convulsions which usher in the disease known as cerebro-spinal fever.

There was no history of any premonitory illness whatever. The child had been at play as usual, and when seized with the attack was accidentally or incidentally noticed by the mother to be staring at a crack in the cupboard and perfectly motionless. The mother, resting her arms on the rim of the pan in which she was washing her breakfast dishes, watched the child a moment and then, becoming alarmed, rushed to him to find him entirely unconscious and about to fall. She then laid him on a lounge and sent for her physician.

Probably thirty minutes had elapsed from the time of seizure before any marked convulsive movements were noticed, the child remaining comparatively quiet, "staring with large eyes" as it was said, and perfectly unconscious.

Noticing an unusual degree of stiffness, rigidity and contraction of the muscles of the neck as of those also of the extremities, more particularly marked on the whole of the left side, the pupils dilated to their fullest extent, the head drawn back, the knees drawn up, the left foot reminding me of a club-foot, the forearms flexed upon the arms, the face red, purple, highly congested, the mouth frothing, eyes open with an occasional clonic winking, more especially of the right, in a word, noticing almost such a convulsion as I have observed in tetanus. I at once felt certain that I had to deal with a case of so-called spotted fever.

I have had some experience in the treatment of this disease, but had never observed a case of it ushered in with a convulsion. In those cases in the treatment of which I had been successful, *I blistered early and relied on opium*. I therefore sent for two drachms of can-

tharidal collodion and a brush and applied it from ear to ear, all over the nape of the neck and down the spine, nearly to the sacrum. I had with me some third of a grain powders of morphia and a hypodermic syringe. Dissolving in a little water about an eighth or a sixth part of a powder, I injected it into the left arm; never having done the like before to a child of this age. In about an hour I applied the balance of the blistering liquid, and noticed while so doing that the spinal muscles responded slightly to the brushing. In a short time the blister began to raise, the pupils became a little smaller, though yet irresponsive, the muscular system gradually relaxed, the face grew paler and assumed to a very slight degree the expression of pain, and his general condition was evidently improving. He continued in about this state until 7 P. M., when partial consciousness returned and he spoke one word. Being now able to swallow, I prescribed bromide of potassium and fluid extract of ergot with an occasional dose of laudanum. During the night he seemed to have considerable irritability of the bladder and passed some bloody urine, the result no doubt of absorption of more or less of the blistering liquid. Not five minutes during the night or since the seizure, did he close his eyes; I therefore increased the doses of bromide and laudanum, and the little patient slept better during the second night. Consciousness did not fully return until Monday, when he wanted to know what made his back and neck sore; his countenance still presenting a bewildered picture with slight corrugation of the superciliary muscle, and his words being uttered with difficult articulation. I now believe he is convalescing from a very dangerous attack of cerebro-spinal fever, which was fortunately nipped in the bud, or, in medi-

cal parlance, aborted. It is my most sacred belief that the child would have died before the expiration of twelve hours had it not been for the treatment instituted.

### OBSTETRICS.

#### Dilatation of the Neck of the Uterus.

M. CHASSAGNY, of Lyons, in a communication made to the Paris Academy of Medicine, describes his method of thoroughly plugging the vagina, and producing rapid dilatation of the neck of the uterus. He places in the vagina a bladder, with which an india-rubber tube is connected; this, with the help of a syphon, conveys into it the water contained in a receptacle placed about two feet and a half higher than the pelvis of the patient. The bladder becomes distended by the water, and soon fills the vaginal cavity. This brings on abundant secretion, and induces energetic contractions, resulting in the physiological dilatation of the os uteri, which is quickly completed by the mechanical action of the bladder. The bladder is placed in the vagina, and the occlusion of the vulva is obtained by means of an apparatus which M. Chassagny calls the *Elyptroptérygoïde* (wings in the vagina). It consists of a cylindrical speculum, which holds the bladder; this is forced out as the water enters, and the act of distension separates the valves of the speculum, which, resting on the sides of the pelvis, prevent the expulsion of the apparatus and of the bladder. M. Chassagny mentions, in his pamphlet, several instances of induced premature labor, in cases of contracted pelvis, obstinate vomiting, eclampsia, etc. M. Chassagny describes two cases of vicious insertion. In both cases he induced labor before the natural period by having recourse to rapid dilatation. There was not the

slightest hæmorrhage, and two living infants were born. In another case, where the mother was in the last stage of suffocative catarrh, M. Chassagny effected, in half an hour, the safe delivery of a living child. The mother rallied for a few moments only. In *post partum* hæmorrhage, the bladder, by completely filling the uterine cavity, closes the openings of the vessels, and, by artificially restoring the pregnant state, determines uterine contraction. The water in the bladder slowly flows away, until the uterus is thoroughly contracted.—*British Medical Journal*.

#### The Vomiting of Pregnancy.

Mr. BROCK discards the numerous theories which have been proposed to account for obstinate vomiting in pregnancy, and believes that it arises simply and purely from an idiosyncrasy in the individual. Vomiting, of course, may be aggravated by other conditions present, such as undigested matters in the alimentary canal, etc.

He thus summarizes his principal reason for coming to this conclusion:

1. That obstinate vomiting occurs in multipara, where the uterine tissues are lax, and where the os is soft, easily dilat-able, and even patent enough to admit the tips of two fingers. This causes him to reject the theory held by Bretonneau and Barnes.

2. That obstinate vomiting is absent in the majority of cases where there is a rigid state of the os, and where one would almost expect it invariably to be present, if the cause were that assigned by Dr. Barnes.

3. That obstinate vomiting is often absent in flexions and distortions of the uterus, and often present where there are no flexions or distortions. This would not be likely if Dr. Hewitt's theory were true.

4. Obstinate vomiting is often absent in inflammatory conditions of the uterus, and present when there are no inflammatory conditions. This ought not to be the case if Dr. Bennett's theory be correct.

5. Because he believes a parallel condition is to be seen in other affections clearly influenced by the individual's neurotic constitution; for instance, obstinate sea-sickness, the occasional vomiting that takes place in pseudocyesis, the proneness to convulsions in certain cases whenever ill; or, to take a specific case, the vomiting simulating the obstinate vomiting of pregnancy, in a non-pregnant woman, in whom the uterus is normal.

6. Because there is no definite line to be drawn between the ordinary cases in sickness in pregnancy and the more severe cases.—*Glasgow Medical Journal*.

#### Observations on Eclampsia.

Dr. H. L. W. BURRITT (*Med. & Surg. Rep.*): I take it for granted that by a large majority of the profession the following propositions are considered axioms:

1st. That bleeding *pro re nata*, as to quantity and according to constitution and strength, is indispensable, and its neglect almost criminal.

2d. That delivery the sooner the better is always the rule, and not the exception, in all cases of eclampsia.

3d. That bleeding being premised, delivery will end the convulsions after half an hour.

4th. That delay is far more dangerous to the patient than the use of any means, manual or instrumental, to the end.

Hence I cannot see any force in the foreign authority or statements, "that delivery does not, as a rule, exert

a favorable influence on puerperal convulsions," and that statistics, as given by Dr. F. Schauta, are unreliable, as his own exceptions—relief of pressure, restoration to the normal state, safety to the child—all deny his facts as given.

All experienced physicians have seen cases of convulsions in women seven to eight months pregnant, where even after bleeding the convulsions persisted until the os was forcibly dilated and the child turned and delivered, often with all the force of traction the attendant could use. I have seen thirteen of such cases without any bad result to the mother. In one case there were fourteen convulsions, six after bleeding to eighteen ounces—seven and a half months—fourth child, weight two pounds eight ounces—forcible dilatation—time, half an hour—only one spasm after loss of consciousness—child now five years old.

Turning is far preferable to the forceps, as there is no obstetrical instrument equal to, and no force so great, that can be used so safely, both in dilatation and extraction, as the *thinking* human hand; its power is sure, and it knows what it grasps, and it gives confidence to the operator. The experience of over a hundred cases justifies my opinion. Who ever heard of a case by a *regular* of injury to the mother where the hands were used alone? Is it not true that ergot carefully used, rupture of the bag of waters and bleeding, followed by early and forcible extraction, have saved more mothers and children in eclampsia than any other method? Bleeding to save the brain, ergot as safety against the hemorrhage of chloroform, forcible extraction to relieve those terrible spasms, immediate relief where an hour's delay may be fatal, and bleeding, above all the anchor of safety—are not these *now* the established *rules* of the profession?

## DISEASES OF WOMEN.

## Visceral Hysteria.

A brief digest of Dr. HUCHARD'S clinical lectures at the Ténon Hospital, Paris, and published in the *Journal de Médecine et de Chirurgie Pratique*.

If the general disturbance of the organism in somatic hysteria, as manifested by its paralysis convulsions, and its sensory and motor disorders, presents features of the deepest interest to the clinician, the study of the localized or visceral perturbations, so numerous and varied in this disease, cannot fail to prove equally interesting.

Some forms of hysteria begin purely as visceral disorders, a fact which, if not thoroughly appreciated, will often mislead the diagnostician. This statement might be well illustrated by the history of a young girl of sixteen, in one of Dr. Huchard's wards, who, before suffering with many convulsive attacks, was troubled for months with strange phenomena about the neck of the bladder that closely simulated the symptoms of vesical calculi. Other forms of this malady, in their incipient evolution resemble the visceral lesions which are peculiar to rheumatism; they affect the internal organs for many months and years, so that they easily become the fruitful source of diagnostic errors. A patient under the care of Dr. Potain, was afflicted with a disease sufficiently obscure to lead several prominent physicians to make successively the varied diagnoses of pulmonary tuberculosis, ulcer of the stomach and tuberculous peritonitis. The last diagnosis had been made in view of the existence of the most violent abdominal symptoms, such as an intense pain and diffused tenderness, which were totally out of proportion with a very small retro-uterine he-

matocoele that really existed. Now, it is well known that in hysterical women "great effects are often the consequence of trifling causes;" it is known that an almost inappreciable lesion engrafted upon a pre-existing hysterical state will often give rise to appearances of such great gravity that it will at times deceive the best clinicians. To illustrate these statements I need only to refer to what is so frequently observed in gynecic practice; the pelvic or ovarian congestions, so frequent among young girls, are they not often the starting points of intense abdominal pains, tympanites, vomiting, etc., etc., a group of symptoms capable of simulating a real peritonitis?

On the other hand, it must not be supposed that because of the mobility of the symptoms and the easy substitution of the phenomena that we have a sufficient proof of the neurotic origin of the malady, on the contrary, in visceral hysteria the morbid condition fixes, roots itself, so to say, in an organ with such obstinacy and tenacity that the practitioner becomes thoroughly exasperated in attempting its eradication. There are nervous coughs which persist for years; pseudo-peritonitic phenomena, which remain immovable for months, and doubtless many have noticed how long some anorexiæ will persist in some cases of scanty urine (oliguria) or suppression of urine (anuria) with uræmic vomiting occur and obstinately refuse to be corrected in spite of the most desperate therapeutic efforts. One of the characteristics of visceral hysteria is to manifest, quite frequently, a torpid, apathetic and rebellious tendency to treatment. Another peculiarity, also, is its permanent residence in an organ, without in the least affecting the organism as a whole. It is, however, a remarkable feature of this neurosis to change

frequently in character without altering its seat, and it thus happens that disorders and conditions of the most opposite nature are seen to follow closely and rapidly after each other in a single organ or viscus; that in the stomach a tonic vomiting frequently supplants spastic vomiting, and hæmatemesis takes the place of gastrorrhœa and vice-versa. The disease may be well said to become proteiform in situ.

We may ask ourselves, why is it that hysteria remains confined for such lengthy periods in the internal organs of some patients while it tends to manifest itself exteriorly or peripherically in others? Very frequently we are at a loss to explain this peculiarity. However, it has been a matter of ancient observation, that hysteria is confined to the internal organs in arthritic or rheumatic subjects more often than in any other class of patients: the older writers, Whytt and Sydenham, believed that hysteria was always the offspring of rheumatism; this view, which is, of course, an exaggeration, is pressed. Again, hereditary, understood in a restricted sense, may exercise a real influence upon the fixation of this neurosis in an organ or apparatus. For instance, we find that patients who are afflicted with gastric hysteria, have had gouty or rheumatic ancestors who have suffered from some disorder of the stomach, such as simple dyspepsia, gastralgia, or even cancer of this viscus; others, again, who complain of palpitations, frequent syncopes, are the issue of mothers who have succumbed to a genuine organic heart disease; another class of patients will sometimes consult us who present the signs of a hysteroid pseudo-tuberculosis (cough, frequent hæmoptysis, dyspnœa, etc.) which can be easily traced to ancestral pulmonary diseases; and, finally, is it not a matter of fre-

quent and well attested observation that intellectual or mental hysteria has its origin in a parentage cerebrally diseased and in whose history mental alienation, mania or other affections of the nervous centers, have played a prominent part? All these facts prove, according to M. Huchard, that side by side with the hereditary transmission of disease, we must place the peculiar hereditary disposition of the various organs, which makes each special organ or viscus the heir of the physiological or morbid peculiarities of its ancestral correlative or homologue.

After these general considerations we are ready to follow M. Huchard in his study of this neurosis as it affects the circulatory and digestive apparatus.

The circulatory apparatus is frequently the seat of trouble among hysterical subjects. In restricting myself to the cardiac phenomena it suffices to mention the frequent syncopes or lypothemiæ, the "violent pains at the heart," the truly nervous palpitations that we must learn to differentiate from a pre-existing or concomitant anæmic state, or, again, from the pseudo-palpitations induced by hyperæsthesia of the precordial wall.

Angina pectoris is comparatively rarely met with in hysteria; it was prominently noticed in 1866, by Mr. M. Friederich and Eichwald, and very recently by M. Marie, who cites two instances especially remarkable on account of the violence and intensity of the vaso-motor troubles. The intra-thoracic pains or pseudo-angina pectoris of hysterical women presents distinctive characters; its symptoms are not so pronounced; its irradiations are less correct, and it is much more capricious in its appearance than the classical angina-pectoris; it is frequently felt at night, and often repeats its attacks without seriously affecting the general health of the patient.

The heart is also the seat of functional murmurs which are not associated with anæmia or any other hæmic condition that might explain them. These morbid sounds appear and disappear with great rapidity and are accountable, in M. H.'s opinion, by the existence of a spasm of the papillary muscles.

At times the cardiac troubles, among which palpitations rank foremost, appear to depend on a disordered innervation of the pneumogastric nerve; for, in such cases, gastric and respiratory troubles rapidly supervene upon the cardiac phenomena. Such a pathogeny was clearly demonstrated in one of Dr. H.'s wards, by a young girl who complained of a tenderness and pain all along the course of the vagus in the neck. She has vomiting spells which are usually preceded or accompanied by the phenomena of suffocation, a croupy, spasmodic cough and palpitations, all signs which confirm once more the existence of the "morbid synergies of the pneumogastric."

Hysteria affects the stomach in various ways: *a*, through a disorder of the sensory apparatus of this organ (gastralgia, painful vomiting from gastric hyperæsthesia, vomiting without straining efforts and due to gastric anæsthesia); *b*, through a disorder of its motor nerves (spasmodic gastralgia, spastic vomiting (?) pylorismus (spasm of the pylorus), gastric atony and transitory dilatations of the stomach); *c*, through secretory and glandular disturbances (flatulence, aqueous vomiting from gastrorrhœa, uræmic vomiting from vicious or vicarious excretion, etc.) Again, we not unfrequently meet, among hysterical subjects, with a hysterical pseudo-gastralgia, in which the pain, instead of being situated in the viscus, is only a superficial tenderness, or pain over the epigastric region.

It is also important, according to M. Huchard, to differentiate between the various forms of hysterical vomiting, the latter term being too broad, according to this teacher, to cover up the diverse conditions which underlie the pathology of vomiting in hysteria. This differentiation should not be made for the sake of diagnostic accuracy alone, but as a matter of decided importance in practice:

1. Vomiting due to hyperæsthesia or to spasm of the stomach, follows shortly after taking meals. The vomiting spells are frequent, painful, accompanied by nausea and frequently followed by diarrhœa. In either case (whether vomiting be due to hyperæsthesia or spasm), opiates before meals (morphia, hypodermically administered) and hot fomentations over the epigastric wall should be resorted to. If pharyngeal hyperæsthesia is superadded to increase sensitiveness of the gastric wall, inhalation of a concentrated solution of potassium bromide, directed to the pharyngeal wall with the atomizer, is indicated and should be used.

2. In another class of cases, vomiting comes on tardily, long after the injection of food, without nausea or pains; it is associated with a distention of the stomach and constipation. It is the vomiting dependent upon gastric atony for its causation. In these cases, opiates are contra-indicated and should not be administered. Stomachics or carminative stimulants, bitters, nux vomica, strychnia, and even faradization of the epigastrium are the remedial agents to be used.

3. Vomiting due to a disturbance of the secretory apparatus of the stomach, such as gastrorrhœa, etc., is manifested by the very profuse emesis of an aqueous or mucous fluid during or after the meals. It is in this trouble that fre-

quent washing of the stomach should be resorted to.

4. Gastrorrhagic vomiting is often the most rebellious of all these various hysterical disorders. Whenever bloody vomiting is supplementary or vicarious to suppressed or diminished menses, the action of the remedies should be directed to the re-establishment of the catamenial flow; in the opposite instance, when the hematemesic spells are due to a vaso-motor trouble (?) in the gastric mucous membrane, then vaso-constrictor remedies such as ergot, or ergotine, the perchloride of iron and quinine, are indicated. Derivative medication will also frequently meet with success; dry cups, blisters and touching the epigastrium with a thermo-cautery are thus recommendable.

5. At times the vomiting spells are preceded or accompanied by cough dyspnoea, palpitation and pain along the vagus in the neck, such cases are properly classified as instances of neuralgia of the pneumogastric nerve (pneumogastralgia). In such cases the repeated application of the constant current will prove beneficial.

6. Finally, another class of cases in which a vomiting takes place, that is characterized by the discharge of a fluid containing urea, and by its occurring in conjunction with the phenomena of anuria or oliguria. These are improperly designated as cases of "uremic vomiting," though they are in reality never accompanied by the toxic phenomena of uremia. They rather represent a supplementary or vicarious vomiting of the renal excreta, strictly comparable to the vicarious vomiting of blood in amenorrhoea. In these patients we frequently have an opportunity to observe the symptoms, which M. Fabrel (of Marseilles) has appropriately classified as "suspensive" or "inhib-

itory" hysteria. In this condition the nutritive processes seem totally suspended, and assimilation and disassimilation arrested. This general nutritive inhibition seems to predominate throughout the glandular system, but is especially noticeable in the secretory apparatus of the stomach, which seems totally paralyzed; the patients eat no more, they cease to urinate, and, notwithstanding all this, manage to maintain their natural "embonpoint." There is a suspension of the absorbent functions and elimination is arrested, so that all medicines taken exhibit none of their physiological properties; the patient is plunged in the therapeutic ataxia or apathy which hysterical subjects not unfrequently exhibit. In these conditions of glandular inactivity, the food introduced into the stomach amounts to just so much foreign material introduced into this organ. Of course it is promptly rejected and thrown up, just as would happen in a case of indigestion from an overloaded stomach.

This so-called uremic vomiting is no more allied to a disorder of the stomach than is the supplementary vomiting of blood in the vicarious hematemesis of amenorrhoea; the functional trouble lies not in the stomach but in the kidneys; therapeutics has nothing to do with the stomach, it has all to do with the disordered kidneys. Unfortunately, however, it is just in such a case that the therapist is totally disarmed; here, the practitioner can achieve nothing by the administration of medicines, for the economy remains totally indifferent to the absorption of aliments and medicines in virtue, purely, of this salutary perversion or suspension of nutrition. Notwithstanding this discouraging knowledge of the impotence of the materia medica, these very cases are the ones that furnish the material for cele-

brated cures; singular, unexpected and almost extraordinary recoveries may result from a sudden strong emotion, by fear, hope or an absolute, blind faith in a physician or his medicines—we thus understand the modest but at times miraculous virtues of the unofficial *pilula micæ panis*.

In all cases of visceral hysteria hydrotherapy is the most important mode of practice. But the douche should not be prescribed blindly and carelessly, as is usually done, for if the stream of water be directed too strongly against painful or histero-genetic spots we will only succeed in exasperating the patient and aggravating the morbid condition.

In treating hysterical vomiting dependent upon spasm of the stomach and especially of its cardiac or esophageal portion, the introduction of foods through an alimentary tube (Faucher's) will often succeed when all other measures will fail.

Such are the principal facts discussed by the distinguished physician of the "Hospital Tenon;" they amply demonstrate the importance that should be attached to the study of visceral hysteria whether we consider it from either the diagnostic, prognostic or therapeutical standpoint.—*New Orleans Med. & Surg. Jour.*

#### Plaster-of-Paris Pessary.

Dr. B. T. DAWSON, before the New York Obstetrical Society, stated (*N. Y. Med. Journal*) that he wished to record that he had made use of plaster of Paris, moulded within the vagina, with the most decided success, in two cases of displacement of the uterus. The first case was that of a woman suffering from anteversion and a very aggravated prolapse of the left ovary. She was placed in the knee-chest posture, and pledgets of absorbent cotton, each with

a string attached, soaked in a mixture of plaster of Paris and water of about the consistence of gum and partially-squeezed out, were placed in the posterior fornix of the vagina and around the vaginal portion of the cervix, and held in position. The vagina was then cleaned out, in a few moments the cast had hardened, and the patient went away with instructions to withdraw the instrument should it cause pain. When she came back at the end of three days she said she had experienced great relief. On removing the plaster pessary, the mucous membrane with which it had come in contact, instead of being irritated, as one might have expected, was found to have been benefited by its presence; it was firmer and less irritable than before, and the prolapsed ovary had evidently been sustained. The second case was one of retroflexion, in which the pessary acted not only as a harmless agent, but seemed to give all the uterine support desired. The instruments were removed, placed in fire to burn out the cotton, and dipped into wax or paraffin for the purpose of making them impervious to the secretions and to render them more durable. This method of supporting the uterus commended itself for the facility with which it could be applied for cheapness and for accuracy of adaptation.

#### Double Ovariectomy, with Firm Adhesions to the Uterus.

Dr. HUNTER operated on a girl on the 5th of February for what was supposed, by himself and others who examined the patient with him, to be a single ovarian cyst, but, upon cutting through the abdominal walls, the tumor was found to be double, and firmly attached to the uterus, which lay in front of it. The contained fluid had the appearance of decomposed blood, but was

not offensive. Some escaped into the peritoneal cavity, but was washed out, and the patient made a perfect recovery after a sharp attack of peritonitis. The pedicle was cauterized with the hot iron. Dr. Hunter also referred to a case, operated upon on the 24th of February, in which the tumor, which was single, was firmly attached to the uterus. The patient made a good recovery.

In corroboration of Dr. Hunter's remarks on the value of the hot-iron cautery applied to the broad pedicle, the President referred to a case in which neglect to use it was probably the cause of the patient's death. Early in October last he operated in a case in which the cyst had formed such close adhesions to the intestines and pelvic organs that its detachment was unavoidably attended by a large amount of oozing. After a double ligature was applied to the base of the cyst the abdominal cavity was sponged out thoroughly, but within three days afterwards the patient manifested symptoms of septic peritonitis, and it was decided to open the wound and remove any fluid that might have been the source of poisoning; none, however, was found. The patient died of peritonitis; but probably, had all oozing been checked in the first place by the application of the hot-iron cautery, the fatal result might have been avoided.

Dr. Hunter remarked that a case was reported by Dr. McFarland in the last number of the *Canadian Practitioner* in which a tumor firmly attached to the uterus was torn off, causing a good deal of hæmorrhage, which, however, was checked by the hot iron, and the patient recovered. Dr. Hunter considered this the best way of checking hæmorrhage from wounds of the uterus in such operations.—*Ibid.*

#### Pessaries in Minor Displacements.

In the course of a lecture on this subject (*Medical Times and Gazette*) Dr. J. MATTHEWS DUNCAN says that intra-uterine or stem pessaries are the only instruments you can rely on for straightening the uterus or keeping a flexion undone. They do this as a male bougie straightens the urethra. The patient's mind must be guided, and you must take care not to let any harm come through your treatment. You may replace a descended or retroflexed or retroverted uterus, and keep it replaced by a pessary, and you may so relieve or remove pains. You cannot cure a displacement, though sometimes you can substitute one displacement for another; that is, for example, change a retroversion into an anteversion. No doubt a displacement may sometimes be, in a sense, cured—as when an adhesive perimetritis ends in tying a uterus up to the higher part of the sacrum. One of the best examples of relief by a pessary is observed in the anteversion (by probe) of an engorged, retroverted and descended uterus.

Here a well-fitted Hodge is comforting and curative, maintaining the anteversion, elevating the uterus, or preventing descent on walking or standing, and preventing relapse into retroversion or retroflexion by keeping the posterior laquear of the vagina pressed against the sacrum.

Another notable example of relief is seen in descent with tendency to cystocele, when the irritation of the cystocele pushing at the orifice of the vagina is most annoying. In such, a suitably-sized Hodge, or India-rubber ring, often, by its anterior limb, just catches the cystocele and obviates the tendency to protrusion through the os vaginae. For each case your pessary must be

specially adapted—a boat-shaped or a double-curved—and it must fit the patient in size and contour. Nothing can instruct you in this but bedside experience. A pessary, if it is to be useful, will give relief at once, and will need very little attention from you. If you are frequently fitting and re-adapting, you are almost surely doing more harm than good. A well-fitted pessary may be worn for months without being attended to. You must take care that the pessary does not cause ulceration and cut the vagina, and you must have a new one placed when the former one gets decayed. You will find it hard to get any good from a pessary unless you have a fair amount of perineum to support it. A pessary will be inefficient if the vagina is not long enough and capacious enough to allow of its action without strong pressure on the vaginal wall.—*Med. & Surg. Reporter.*

#### Ergotine Suppositories.

M. LIEBRECHT, of Liège, has found that ergotine administered in this way is very rapidly absorbed, its action is energetic, and it provokes no pain. With smaller doses than are usually employed in hypodermic injections, equal or even superior effects are obtained. The following formula is serviceable:  $\mathcal{R}$  Dialyzed ergotine,  $1\frac{1}{2}$  grams; ol. theobromæ,  $1\frac{1}{2}$  grams; vaselinæ,  $\frac{1}{2}$  gram. M. For one suppository; three may be applied weekly. The uterine affections, in which injections and suppositories of ergotine are of benefit, are: Fibroids, menorrhagia, metrorrhagia after labor, at the period of the change of life, or when tumors are present; finally in chronic metritis and endometritis. For hypodermic injection, M. Liebrecht uses exclusively pure dialyzed ergotine.—*Ibid.*

#### Treatment of Neuralgic Metrorrhagia.

Uterine hemorrhage, occurring in connection with lumbo-abdominal neuralgia, is a condition which is pretty generally recognized, and one for which treatment is, as a rule, unsatisfactory. A writer in the *Revue Méd. Chir. des Mal. des Femmes*, claims to have employed with success the tincture of aconite in repeated doses. The only indication for its use is the establishment of a relation between the neuralgic exacerbations and the return of hemorrhage. Even in cases depending upon actual lesion of the uterus, the writer asserts that we can always obtain a favorable remission, if not a permanent cure. The tincture is given in drop doses, in a teaspoonful of water, every fifteen minutes for six hours. No food is to be taken in the meanwhile. On the following day, if the symptoms are ameliorated, the aconite may be repeated in the same dose. If there is no improvement the dose is to be doubled. The maximum daily dose necessary to arrest the hemorrhage is said never to exceed forty-five to fifty drops. But this is an amount of aconite that might give rise to serious symptoms, and the effects of the drug should be very carefully watched.—*Med. Record.*

#### Cauterization of Clitoris for Hysteria.

In neuropathic females, Dr. N. FREIDERICH (*Virch. Arch.*, vol. xc.) believes that an over-sensitiveness of the sexual organs, acting upon the spinal and cerebral centres, may cause hysterical symptoms. He has treated eight such cases by cauterization of the clitoris, and, though a painful operation, every case has been ultimately cured.—*Med. and Surg. Reporter.*

## DISEASES OF CHILDREN.

## Infantile Leucorrhœa.

Clinical lecture by Prof. T. GAILLARD THOMAS (*Med. and Surg. Reporter*):

GENTLEMEN—The little girl, nine years old, whom I first bring before you, is suffering from a very profuse leucorrhœa, which, her mother informs me, she has been unable to cure by any of the remedies which she has employed, and which has now lasted for two months. I, of course, made a vaginal examination, and, on separating the labia, I found that the whole vulva was about the color of red flannel, and bathed with a copious leucorrhœal discharge. The meatus urinarius was also seen to be in the same condition, and urethritis has, no doubt, been set up by the spreading of the irritation. If it had been necessary, I could have introduced a small glass speculum into the vagina; but this was not required to make a diagnosis, as I saw exactly what was the matter without resorting to this.

Not infrequently mothers will bring their little girls to you in this condition, and they will sometimes be in a state of great agitation, because they are afraid the trouble has been the result of injury done the children. There is ordinarily no reason whatever to suspect anything of the kind, and you can at once quiet the anxious mother's mind. The affection is a perfectly simple one, and is perfectly curable also. What is it, then? It is generally known as infantile leucorrhœa; but infantile vaginitis would be a better term for it.

Now as to its causes. One of the most frequent of these is neglect of hygienic precautions. There is generally no intentional neglect on the part of the mother or nurse; but, on account of the undeveloped condition of the part, an

accumulation of hardened secretion sometimes collects in the same way as that which not infrequently gives rise to balanitis in the male child. Another common cause is the depreciated condition of the child's system, such as that due to spanæmia, in which all the mucous membranes are apt to become more or less affected. Thus, there is often gastric and intestinal, as well as nasal catarrh. A third cause that may be mentioned is reflex influence from the rectum. The cause of the irritation in the rectum is usually *ascarides*, and an afflux of blood to the part is caused by the itching and irritation.

In some instances, the *ascarides*, by getting into the vagina itself, are the direct cause of the trouble. The prognosis of this affection is, that it can be cured at once if it is properly treated.

In the treatment, the first thing to do is to see if there are any worms present, and if so (or there is any reason to suspect that such is the case), use an injection of warm salt water, as this form of *ascaris* (the *ascaris vermicularis*), as well as others, is unfavorably affected by salt. The next thing to do is to get the child's general system in the best condition possible by appropriate food, iron, vegetable tonics, and the hypophosphites. It is better to depend on nourishing diet, however, than on medicinal agents. If after the worms have been gotten rid of the vaginal irritation and discharge should continue, or if no worms should be found to be present, local treatment will be required. The vagina should be thoroughly washed out by means of a syringe provided with a small nozzle, which ought to be well oiled before being introduced. In order that the canal may be perfectly cleansed, the child should be placed upon the back. In some cases the mere removal of the accumulated secretion, which is a con-

stant source of irritation, is all that is necessary; but if the trouble has gone on for some time, this may not be sufficient. Something further is then needed, and one of the best applications to use is the old-fashioned black wash (calomel and lime-water) in the strength of one ounce to the pint of water. Before using this (which should be done twice a day) an injection of simple warm water should be made. I have never yet seen a case of infantile leucorrhœa that could not be cured by such treatment as this; so that there is no necessity of resorting to astringents and nitrate of silver, which may perhaps do harm. If it is adopted here, I have no doubt that in less than two weeks this child will be entirely well.

But there is one mistake which is apt to be made by the physician in these cases, on account of which a much longer time may be required for a case than is at all necessary, and that is, the failure on his part to show the mother or nurse how to introduce the nozzle of the syringe properly. Mothers, unless they are especially instructed in regard to this point, never carry the nozzle more than an eighth of an inch up into the vagina, and as it is above this that the degenerating pus is found, there will be no improvement, simply because the injections fail to reach the real source of trouble. It is not enough even to show the mother how to use the syringe, but you should also watch her do it, and see that the upper part of the vagina is reached. In a child of this age, the rectal tube of a Davidson syringe should be employed.

#### Chronic Hydrocephalus.

Clinical lecture by WM. T. PLANT, M. D.

*Gentlemen*:—Our topic for to-day is hydrocephalus. This you will rightly

guess to be a collection of watery fluid in the head. It has also been called cerebral dropsy.

It is a disease of early life, beginning in most cases within the first half year. It may, indeed, occur to adults, but as it cannot cause enlargement of the ossified skull its recognition before death is most difficult. The gifted Dean Swift, author of *Gulliver's Travels*, died, it is said, of this disease, when 78 years old. Irritability, melancholy, stupor and finally complete dementia marked the last three years of his life.

Hydrocephalus may commence before birth, expanding the head so much as to cause a very tedious labor, or even compelling a resort to the perforator to reduce the size of the head. We speak of this as the *congenital* variety, as we do also if the enlargement begins very soon after birth. When it occurs so late that it evidently has no connection with the foetal state it is known as *acquired* hydrocephalus.

There is also another division. Usually the fluid is within the ventricles; but in some instances it is outside the brain, within the sac of the arachnoid. The former is called *internal*, the latter *external* hydrocephalus. The precise seat of the accumulation is not easy to make out during life, nor is it practically very important that it should be done.

The amount of fluid is very variable, depending on the duration of the disease and on the extent of union between the bones. With firm sutural union but slight increase in the capacity of the skull is permitted, though instances are recorded where, in children seven, eight, and even nine years of age the bones have been forced asunder at the sutures by the accumulating fluid. If, as in the congenital variety, there is no sutural union, the capacity for expansion is wonderful. The head may

be more than two feet in occipito-frontal circumference. Trousseau cites a case in which this measurement was more than thirty-nine inches, and in which the skull contained thirty pounds of fluid.

If the hydrocephalus is internal, the ventricles may be so distended as to occupy nearly all the cranial cavity ; and the brain, yielding before the pressure from within, parts with its convolutions and becomes spread out into a thin lamina like a pie-crust ready for the oven. When the dropsy is external the cerebrum and the cerebellum are usually found crowded into a small space at the base of the skull.

The bones at the vault are often separated by more than a finger's breadth, and the anterior fontanelle may attain a diameter of five or six inches. Union of the bones at the sutures is, of course, greatly retarded, but it does finally occur if the child lives, and in this way : Long, finger-like processes are sent from bone to bone across the gaping spaces, and between these are developed later, triangular Wormian bodies. Ossification does not always occur with the regularity that obtains when nature has not been thwarted in her plans, but irregularly, one suture uniting before the others, so that the fluid still accumulating spreads the head more in some directions than in others.

The cause or causes of this strange malady are rather obscure. I think the opinion is gaining with the profession that the essential cause is a slow inflammation of the arachnoid ; and in internal hydrocephalus, of that part of the arachnoid lining the ventricles. Probably a tendency to it may be inherited. Marriage between blood relatives, drunkenness and syphilis are asserted causes of it in the offspring.

*Symptoms.*—If congenital, there are signs of cerebral disturbance soon after

birth, such as squinting and oscillation of the eyes, convulsions, gradual enlargement of the head and progressive emaciation of the rest of the body. Though the appetite may be voracious, nutrition is at fault and the infant becomes lean and shriveled. When the head has attained a certain size, it is no longer held upright on the shoulders, but, unsupported, it rolls and topples helplessly this way and that. At times it is hot and the patient restless. Pulsation may occasionally be felt through the expanded fontanelles and sutures. When the accumulation is large, fluctuation is well marked. While the head grows in all directions, there are yet some peculiarities about the enlargement. The bones of the head are most movable at their upper parts, and from this it results that the top of the forehead becomes very prominent and the parietal bones flare outwards something like the sideboards of a butcher's wagon. Owing, as Henoch says and as I believe, to paralysis of the fibres of the motor-oculi supplying the superior rectus muscle the eye-balls are turned downward so much that the pupils are half concealed beneath the lower lid. Strabismus is nearly a constant symptom, owing to paralysis of other branches of the motor-oculi nerve. Deep blue veins, which the few scattered and stunted hairs do not conceal, course lazily over the tense and shining scalp. The face, sharing in the general emaciation, loses its oval contour and becomes pinched and wasted. It is pyramidal in form, with the base at the eye-brows and apex at the chin. The diminutive countenance with its old and solemn look ; the over-hanging forehead and the down-turned eyes make a peculiar physiognomy that is known as the "hydrocephalic face."

Usually the intelligence is early affect-

ed and the child becomes stupid and semi-idiotic. There are some exceptions to this, and cases are recorded where hydrocephalic children have shown a phenomenal mental vigor.

The disease advances, but not with steady march. There are frequent pauses when the child seems brighter and the parents begin to think about recovery, but their hopes are illusive. The sight becomes impaired and is at length wholly lost. The hearing is affected in the same way, but later. Convulsions, varied in degree and in the muscles they affect, are common. Vomiting, constipation, and in sleep restlessness, with grinding and gnashing of the teeth are pretty constant symptoms. Death is most always by coma.

The course of a hydrocephalus is generally completed within a year or two. But beware of limiting the time in your prognosis. Cases in which it seemed neither possible or desirable that life should be prolonged for any time have lasted five and six years.

In a few instances the subjects of congenital hydrocephalus have lived to maturity and have then succumbed to some other malady, to which indeed there is always a liability.

In the *acquired* form, enlargement of the head is not an initial symptom as in the other, and perhaps not at all. Probably the first symptoms to attract attention are the failing nutrition, paroxysms of atrocious headache and convulsions. When the malady occurs after firm sutural union, symptoms of compression appear early and death soon occurs—usually within a few weeks.

*Treatment.*—Not much time need be given to the consideration of any treatment hitherto employed since little success can be claimed for any plan. I will tell you briefly some things that have been done.

One plan has been continuous strapping of the head with adhesive plaster, or enclosing it with plaster of Paris to limit expansion. It has met with little favor or success. If applied tightly there is danger of over-compression, and if not tight it can do little good. So long as the over production of fluid continues it would be illogical to expect a cure through such means. We would never think to cure an ascites by calling in a cooper to bind the abdomen with hoops. I should state, however, that there are some favorable reports of this way of treating hydrocephalus, and especially as an aid to other treatment.

Drawing off the fluid through a fine canula introduced at the caronal suture has now been many times practised. The operation seldom does any harm when properly done, and though generally of no avail, it has been reported as completely successful in a number of cases.

Iodide of potassium in full doses coupled with the use of iodine in lotion or ointment externally has succeeded in some cases. This was Trousseau's favorite treatment. Blisters over the scalp and to the back of the neck have had many and still have some advocates. I cannot find that there is much evidence in their favor.

Prof. Gölis, of Vienna, some years ago proposed a plan of treatment that has given some favorable results—more, I believe, than any other. It is this: Rub daily into the shaven scalp a drachm or two of a dilute mercurial ointment. Give minute doses of calomel—from a sixth to a quarter of a grain twice daily. Keep the head constantly covered by a flannel cap. If the bowels become loose the calomel is to be discontinued, but the inunction may be employed for many weeks.

Through one or another of these plans

you may be so fortunate as to see some cases recover, but generally your treatment of hydrocephalus will be disappointing.

#### Trismus et Tetanus Neonatorum.

Dr. EPPSTEIN's Clinic, Prague (*Obstetrical Gazette*): This child is eleven days old, and yesterday, for the first time, showed that it was ill by refusing the breast. Its weight has decreased considerably, the skin is a pale yellow, the muscles feel stiff, the extremities are bent, the fingers clinched, the head is fixed backwards, the forehead is wrinkled, the *alæ nasi* dilated, the lips parting half opened and pointed, reminding one of a fish's mouth, the jaws so firmly closed as to make opening the mouth for an examination impossible. The face around the mouth is bluish, the features have a mask-like immovability, the breathing is painful and irregular, the thorax anteriorly pretty well thrown out and showing in the back a kyphotic curve. The umbilicus is slightly ulcerated, the skin reddened around it.

We have here a tonic muscular rigidity to deal with. The heart is normal, the percussion-note a trifle less sonorous, the temperature is slightly increased. We get two or three cases yearly in two thousand five hundred births. Death is the termination in most cases. The child cannot nurse, the respiratory muscles are crippled in their work, and the temperature is generally high, increasing, as in adults, towards death, and even beyond it. Pathological anatomy does little for us. The hyperemia of the brain, spinal cord and their meninges, the fullness of the heart and venous trunks, and the oedema or hyperemia of the lungs, which, the autopsy shows, are secondary. The appearances resemble those in death from suffocation or strychnine poisoning.

The etiology is yet quite obscure. In most cases there exists trouble at the umbilicus, superficial ulceration or suppurative inflammation of the arteries or veins. The case preceding this had an umbilical hernia. It would be difficult to prove that this disease originates in a septic infection, though some things point in that direction. Soltmann's experiments with animals gave negative results, and does not disprove the fact that it may be of septic origin. It is certain that it is oftener observed in certain unfavorable hygienic circumstances, and under such circumstances becomes epidemic in lying-in and foundling establishments. And that when these conditions were bettered the disease disappeared. Unusual thermic irritation causes it, as putting infants in too hot water for their first bath. It is especially frequent in the torrid zones, and among negroes who are unclean and careless in dressing the navel. Carefully-supervised inhalations of chloroform may be tried, as treatment, hourly. Monti has used calabar successfully—others recommend musk in drop doses. The autopsy of this child a few days later showed arteritis umbilicis, hyperæmia of brain and spinal cord and oedema of the lungs.—*Ibid.*

M. STANTON.

#### Mastitis.

Dr. EPPSTEIN's Clinic, Prague: This infant is twelve days old, well developed and nourished, and but for an affection of the right breast, perfectly healthy. The right breast is swelled, reddened, the nipple sunken, and palpation gives distinct fluctuation. We have an inflammation of the glandular tissue, a condition not uncommon in children of this age. The breasts of new-born children, boys as well as girls, resemble, in some particulars, those of a lying-in

woman; they swell and contain a milk-like secretion and feel knotty. The secretion under the microscope bears out the resemblance, although the corpuscles are not as abundant as in a woman's milk.

Chemical analysis also shows the similarity of the two fluids. It seems to sustain some relation to that peeling-off process that takes place not only in the skin and mucous membranes, but in the salivary, oil, sweat, and other glands. A section of the milk gland at that time shows its ducts widened and filled with epithelial debris. This clinical observation may have some physiological significance—the desquamation and disintegration of the glandular epithelium may relate in some way to the origin of the milk. The quantity of milk is sometimes so great that an incision causes it to flow free from the products of inflammation. In some cases there is a circumscribed phlegmonous abscess, entirely independent of the gland, again part or the entire glandular tissue may be involved. The pus can break into a large duct and stream from the nipple, or one lobe after the other is affected and necessitates several incisions. In exceptionally unfavorable cases the abscess may extend over the thorax open in an intercostal space and occasion a fatal pleuritis. Mastitis is either primary or secondary. It attacks healthy children as well as those who are suffering from other suppurative processes or other diseases. It is often the first symptom of pyæmia. Cover the glands with cotton—in making incisions, especially with girls, cut radiating from the nipple.—*Ibid.* M. S.

#### The Cold Douche

Was employed by Dr. BROADBENT (*British Medical Journal*) in a case of sleeplessness and pyrexia after child-

birth with great relief to the patient. There had been no sleep obtained for several days, and besides this there were pyrexia and severe abdominal pains. The temperature was 14° F. She was restless and tossing about in bed, with a flushed face, bright eyes and a wild and anxious expression of countenance, the skin being covered with perspiration. The pulse was 120 and the milk was suppressed. There were no symptoms of peritonitis or septicæmia, nor did the tenderness over the left iliac fossa indicate cellulitis or ovaritis. The cold douche was therefore used as follows: The patient was first sponged all over with tepid vinegar and water, and then a large bath sponge as full of ice-cold water as possible was dashed against the head, chest and back two or three times, the skin being dried by a coarse towel between the applications. A calm sleep speedily followed, the pain in the iliac fossa disappeared and the temperature fell, and a satisfactory convalescence took place.—*Weekly Med. Review.*

#### Peritonitis Neonatorum.

Dr. OSCAR SILBERMANN recognizes two varieties of peritonitis in the new-born. The non-septic or chronic form is developed usually in the first third of foetal life, and is generally syphilitic in origin. If the peritoneum covering the intestines be involved, as well as that over the liver and spleen, various forms of intestinal obstruction may result. Most frequently we find occlusions of the anus, less often stenosis or complete occlusion of the small intestine. Of a number of cases of congenital occlusion of the intestine, collected by the author, all ended fatally, only one living beyond twelve days. The second, acute or septic, form of peritonitis in the new-born the author divides into two varieties, according as the peritonitis is only a

part of the general infection or is the sole manifestation of the septic poison. In either case the point of entrance of the poison is always at the navel wound. The symptoms, which need not all be present in a given case, are vomiting, watery stools, meteorism, ascites, abdominal tenderness, icterus, etc. The pulse, temperature and respiration may vary in degree in the different cases. A cure of the septic form is possible; therefore, the treatment should be carefully considered. The navel wound must be cleansed, and the child is to be isolated from its mother. To control the fever quinine may be given. The Priessnitz sheet is of value. Vomiting may be checked by chloral (one-half to one grain in water). The strength should, of course, be maintained by stimulants, if necessary. — *Schmidt's Jahrbücher*. — *Med. Record*.

#### Vaccination with Saliva of a Calf.

Dr. T. J. REID, of Hot Springs, Ark., writes to the *Louisville Med. News*: "Quite recently my attention has been called to an accidental vaccination of a respectable lady in this vicinity with the fresh saliva of a calf while sucking. This lady had on the index finger of her right hand two *nævi* or small warts. While milking her cow the calf annoyed her, and she (lawfully in this State), gave it a back-handed slap and, striking one of the *nævi* against the calf's tooth, contused or wounded it so as to cause it to bleed a drop or two. About a week or ten days thereafter it inflamed, causing the hand and arm to swell, with rigors and considerable febrile excitement. The pustule was well formed, umbilicated and desquamated about the twenty-sixth day. All the ordinary phenomena of a well-typed bovine vaccination, and the characteristic eschar supervening, caused me to question,

what is the true bovine vaccine. If the distinguished Jenner was mistaken as to how this bovine vaccine was acquired, and instead of the grease, a disease of horses' heels being the medium through the cow, it is the fresh saliva of a calf, we should experiment sufficiently to ascertain the truth." — *Med. Med. Jour.*

#### OBSTETRICS.

##### Iodoform Suppositories in Puerperal Septicæmia.

In the *Canada Med. Record*, Dr. ALLOWAY presents the records of six cases of puerperal septicæmia, three of which had been treated by a new method, viz., the introduction into the uterine cavity of iodoform suppositories. In carrying out the treatment he uses a Sims' speculum, washes out the uterus first with plain or carbolyzed water, and then, with a tent-inserter, passes the suppository far up into the fundus. He uses them of the strength of ten, fifteen, or twenty grains, and usually introduces one night and morning. No poisonous effects have been noted.

[The following formulas from the June number of the Kings County Proceedings are of interest in this connection:  $\mathcal{R}$  Iodoform pulv., gr. x.; vel., xx.; mucilag. gum arab., glycerinæ,  $\text{āā.}$ ; pauxill ut fiat massa, ex qua form. bacill. longit.  $\mathcal{R}$  Iodoform pulv. ol. theobrom.,  $\text{āā gr. x.};$  vel., xx.

Gelatine is probably not so good an excipient as the above, owing to its tendency to putrefactive change.] J.

##### Laceration of the Perinæum

Is one of the commonest yet most deplorable accidents attending parturition. To guard against it, Mr. ALEXANDER DUKE recommends, in the *British Medi-*

*cal Journal*, that when the child's head is fairly engaged in the pelvis, and advancing with each pain, the left thumb or the first two fingers of the right hand, well lubricated, be introduced into the vagina at the beginning of a pain, and firm but gentle traction made upon the perinæum towards the coccyx, the tension being gradually relaxed as the pain passes off, to be renewed when another begins. He says that by this procedure the muscular structure is tired out and sufficient relaxation produced for the head to pass; that in most cases so treated there is no danger to the perinæum and the patient suffers no additional pain, as it is done during an uterine contraction.

#### A New Instrument for Exciting Uterine Contractions by Electricity.

A novel instrument was presented at the meeting of the Academy of Medicine, held February 22, 1883 (*Gazette Des Hôpitaux*), by M. DUJARDIN-BEAUMETZ for M. Apostoli, which has for its object the substitution for the unipolar method of faradisation—now exclusively employed, in which one pole is placed in the uterus and the other pole on the abdomen,—the bipolar method in which both poles are carried into the uterus.

It is claimed for this new method :

1st. That it is more easily employed and does away with the necessity of an assistant.

2d. That it is less painful.

3d. That it is more active, localizes the action of the electricity in the uterus, permits of an easy elevation of the intensity of the electricity to the maximum point which was only rarely possible by the unipolar method.

4th. It is more effective in increasing uterine contractility and in securing the therapeutic effects for which it is directed.

The instrument consists of a hollow

stem of sufficient length to reach the fundus of the uterus, and of suitable size to admit of easy introduction through the cervix. At the end of the stem are placed the positive and negative poles, separated by a short disc; through the handle of the instrument pass the two wires connected with the battery. The currents are carried through the stem to the electrodes which may be brought in contact with any portion of the uterine cavity.—*Md. Med. Journal*.

#### Shall Carbolic Oil or Vaseline be Allowed to Retain Our Confidence as a Reliable Disinfectant Lubricant in Obstetrical Practice?

FEHLING, of Stuttgart, discusses the question in a recent number of the *Cent. f. Gyn.* Mixtures of carbolic oil or vaseline have been used for several years, and are still much employed for such purposes. Koch's recent researches are pertinent to this question, and tend to destroy confidence in the parasiticide properties of carbolic oil. He found that anthrax bacillus and its spores could be kept in carbolic oil for more than three months and retain their vitality. He also found that these spores retained their vitality as long in carbolic oil as in olive oil. Bacteria, moreover, are found, and continue to develop, in catgut preserved in carbolic oil. The most important lessons to be derived from these facts is that the disinfectant power of carbolic oil upon the fingers must be very slight, insufficient, and, therefore, dangerous.

[Vaseline as a lubricant in obstetrical practice may be carbolized with ten per cent. of carbolic acid to make it aseptic, not antiseptic. For antiseptic purposes aqueous solutions of three to five per cent. strength should undoubtedly be preferred to solutions in oil media.] J.

**On the Diaphoretic Treatment of Puerperal Eclampsia, with Hot Baths.**

Our readers will remember that in a previous report I embodied a *résumé* of the results obtained by this method of treatment at Prof. GUSTAV BRAUN'S Clinic, Vienna. Dr. Carl Breus, his assistant—the writer of the previous article—again appears in the last number (B.I. XXI, Hft. 1, of the *Arch. f. Gyn.*, 1883), with a report of eleven other cases, treated in the same way; of these eleven only one died, the other ten recovered—as the author remarks excellent results in such a serious disease. It will be remembered that the procedure consists in placing the patient in a bath of a temperature of 38° C., and gradually raising it. After the bath the patient is wrapped in warm sheets and blankets to encourage perspiration. This method of treatment in no way interferes but rather favors the carrying out of other indications for treatment, such as chloroform inhalation, chloral hydrate enemata, etc. A sketch of the history of each case is appended. Of the eleven cases, in four the eclampsia occurred in the beginning of labor; in two after long duration of the first stage; once during the expulsion of the child, and four times after labor. The fatal case was syphilitic; was brought late to the Clinic for treatment, and had had many convulsions. She was, moreover, also probably in a condition of septic poisoning when brought in, as death was not caused by the eclampsia, but by pelvic phlegmon and peritonitis four days after delivery, when the evidences of kidney affection had become very much diminished. This series affords a better showing for the treatment than the first series of six cases, of which one died. To sum up, of seventeen cases two only died. One only of the

deaths being due to convulsions, the other as just related to puerperal peritonitis. Experience of the treatment has shown that it in nowise exposes the patient to the danger of premature labor. In two cases in which convulsions came on before the end of the full period of gestation, and which were treated by the baths and other diaphoretic procedures, labor did not come on till the end of full time.

Further evidences of the facts here stated are afforded by the results of preventive treatment of several cases of œdema and albuminuria in pregnant women at the Clinic. In one notable instance a primipara, æt. 26, with bloody, highly-albuminous urine, was transferred in the eighth lunar month of her pregnancy from Bamberger's Clinic to the Obstetrical Clinic for treatment. She was so dropsical that she could scarcely turn in bed, and suffered from intense dyspnœa from œdema of the bronchial mucous membrane and hydrothorax, aided, of course, by the normally lessened descent of the diaphragm by the gravid uterus in advanced pregnancy. She was treated with hot baths and packing. For more than ten weeks she was thus treated—forty-five baths in all having been thus given. The first baths markedly relieved the dyspnœa, lessened the œdema, and markedly reduced the quantity of albumen and blood in the urine. When on one occasion the baths were suspended on account of diarrhœa, the distressing symptoms returned. The patient was delivered spontaneously of a living child. The only interference being bilateral episiotomy, or incision of the perineum, rendered necessary by the œdema of the vulva. She died, however, later of an attack of pleurisy in Bamberger's Clinic, to which she had been removed for further treatment of her nephritis.

## DISEASES OF WOMEN.

**The Treatment and Curability of Chronic Uterine Catarrh.**

Dr. PAUL F. MUNDÉ (*Med. Record*): If the patient is a virgin or a nulliparous married woman, it will generally be found necessary, after thoroughly exposing the cervix (in the virgin usually at the expense of the hymen), to enlarge the external os. This is essential for two reasons: first, to give free vent to the accumulated endocervical mucous, and second, to allow the ready application of the remedies. This little operation is best done in the following manner:

The cervix being exposed through a Sims (or after a fashion through a large cylindrical or bivalve) speculum, a Sims uterine knife, or simple bistoury, or straight scissors, is passed about one-fourth of an inch into the cervical canal, and the anterior lip is divided by one quick stroke; the instrument is then turned against the posterior lip and this also is incised, and the same is done with each lateral lip. Four incisions have thus been made, each about one-fourth of an inch deep, completely dividing vaginal and endocervical mucous membrane, and making the external os nearly or quite as large as the calibre of the cervical cavity. In order to insure this opening against speedy closure, it is imperative that the four flaps of mucous membrane formed by this cervical incision be removed. If this is not done, even frequent sounding and forcible dilatation will not prevent the flaps from re-uniting, and in a few weeks the external os is as narrow as ever. I have invariably met with this result when I left the flaps *in situ*, and hence have adopted the plan of seizing each flap with a fine tenaculum and trimming it

off with curved scissors, so as to have a funnel-shaped external os. The raw surfaces of this slight wound soon cicatrize over, and the os retains its funnel-shape.

It is not necessary to perform this operation in every nullipara; indeed, in many the discharge has rendered the os patulous, the examining finger easily enters it, and its lips are pulpy and eroded.

I have found the same conditions in virgins and married nulliparæ.

After the os has been enlarged, the next step is to destroy, as thoroughly as possible, the cervical glands which furnish the annoying mucous secretion. To do this effectively, once and for all, take a sharp curette, with cutting edge (Sims's or Simon's), and scrape the whole cervical canal up to the internal os until the creaking sound tells you that the subglandular base has been reached. Do not be afraid to do this thoroughly, since no harm can be done, and unless the glands are entirely destroyed, their secreting power is liable to survive. When the whole canal feels smooth, apply, on a cotton-wrapped applicator, or, what is better, a wooden or glass rod, pure nitric acid, being careful to protect the external surface of the cervix and the vagina by packing cotton underneath. This application must be so thorough as to give the cervical canal a charred, yellowish-black appearance, with not even a drop of blood issuing from it. In order to effectually protect the cervix from the acid, I frequently use the cylindrical speculum after curetting. Any excess of acid should be mopped up with cotton, and several tampons covered with vaseline placed against the cervix.

In some instances I have merely applied the iodized phenol (equal parts), or saturated solution of chromic acid.

But I prefer the nitric, as more efficient and scarcely more painful. If the patient is a multipara, it is rarely necessary to enlarge the external os; indeed, it is generally lacerated, and more or less gaping. And sprouting from the surface of the everted lips will be found more or less numerous fungoid granulations, which are partly enlarged papillæ, and partly distended follicles. These must be removed in order to cure the hypersecretion, and to put the cervix in proper condition for the plastic operation of Emmet. The sharp curette is here also an excellent instrument, although the curved scissors are often more rapid and efficient in removing large and tough vegetations.

It is these same papillomatous growths which to the comparatively uneducated touch feel like epithelioma, and give rise to mistaken diagnoses and unfavorable prognoses. A mere clip of the scissors removes them, and leaves a clean, smooth, although raw surface, which needs only to be attached to its opposite fellow by sutures to effect a cure.

After removing these granulations the surface should be painted with tr. iodine, or sol. arg. nit. (3 j. to 3 j.), or iod. phenol; or, if the production of a superficial slough appears desirable, nitric acid should be applied and an emollient tampon inserted.

A very common condition is that of cystic hyperplasia, the everted surfaces being dotted with numerous small translucent, more or less prominent, spots, which are simply occluded cervical glands (Nabothian follicles). Every one of these must be punctured with a bistoury or scarificator, and its cavity obliterated by thorough swabbing with tr. iodine, or it will be a constant source of mucous secretion, and its presence will interfere with union if trachelorrhaphy is performed.

The operation of crucial incision of the external os, followed by the sharp curette and nitric acid to the cervical cavity, had better be performed at the residence of the patient, and the latter kept quietly in bed for a day or two at least. It is not that it is attended by special danger; indeed, I have performed it many times in my office or the dispensary, and seen no bad effects from it. But within the past two years I have met with three instances of unfavorable reaction to this treatment, which has induced me to observe the precautions usually advisable in all operative procedures about the uterus. Two patients upon whom I practised this method at my office during one winter disregarded my positive directions to go home at once and remain quiet during the remainder of that day, but went down town shopping. It was a cold, damp day, and, as a result, within a few days I was called and found severe pelvic cellulitis, which confined them to their beds for several weeks. During the past winter I scraped away some fungoid granulations from the external os of a patient at Mt. Sinai Hospital, and applied pure nitric acid; she was at once put to bed, but a furious cellulitis ensued, which kept her in the hospital for several months. These are the only cases out of several hundred treated in a similar manner which have been followed by the slightest unpleasant consequences. I have also curetted the cavity of the uterus proper many, doubtless several hundred, times, and in perhaps twenty cases have swabbed it out with pure nitric acid; in only one instance did a cellulitis follow. I am inclined from this experience to look upon the cervical canal as rather more susceptible to inflammatory reaction from this operation than the uterine cavity, especially when a severe caustic, like nitric acid, is

applied; and I believe this greater liability to be due to the intimate relation of the cervix to the lymphatics which abound in the paracervical cellular tissue. While applications above the internal os are more liable to produce shock and peritonitis, those to the cervix are more frequently followed by inflammation of the pelvic cellular tissue.

In spite of this danger, the severe measure (sharp curette and nitric acid) is by far the most advisable, because it is the most effectual. I have never as yet found it necessary to substitute the actual cautery, so warmly recommended by Sims; but I have resolved in the very next case which proves rebellious to the acid to use the Paquelin long slender tip, and thoroughly sear the cervical cavity up to the internal os. The danger of thereby contracting the latter orifice should be borne in mind.

As for catarrh of the endometrium proper, I seldom use the sharp curette above the internal os, except when it is my purpose to remove vegetations or hyperplastic mucous membrane of unusual exuberance, or where the dull curette has not prevented the return of the disease. And then, also, I am tempted to follow the curette by fuming nitric acid, and have seen none but good results follow this apparently heroic treatment. But, as a rule, I find the dull curette and milder caustics (iodized phenol, co. tr. iodine, sol. arg. nit., 3 j. to 5 j.) sufficient to effect an improvement.

The soluble gelatine pencils containing these ingredients (except the nit. silver), and also iodoform, sulph. zinc and copper, have at times been beneficial in my practice; but the difficulty occasionally encountered in keeping them in the uterine cavity, and their tendency to produce uterine colic, owing to their frequent insolubility, has somewhat de-

tered me from using them as often as I should have wished to do. If they are readily soluble (and those made by Mitchell, of Philadelphia, and especially those of Fleischer, of 652 East Sixth street, (in this city, are unusually so), these pencils, by their long contact with the diseased surface, are decidedly preferable to fluid applications. They are retained in the uterus by flat tampons over the external os.

As a rule, I think that where an immediate, positive effect is desired (styptic, astringent, caustic), fluid applications on cotton-wrapped applicators are preferable; where a steady, gradual alterative influence is called for, soluble bougies are indicated.

The nitrate of silver is usually prepared in pencils by fusing with nitrate of potash, in various proportions; it is particularly liable to produce uterine colic in this form, and I have never thus employed it.

An indispensable condition to the safe and effectual application of caustics to the endometrium is the patulousness of the uterine canal, particularly the internal os. Fortunately this is usually the case, the discharge softening the tissues and dilating the canal. But when nitric acid is to be applied it is always well to secure a canal of sufficient width to permit the easy insertion up to the fundus of a straight rubber stick wrapped with cotton, and a previous dilatation with a tupelo tent for a couple of hours will attain this end.

Whether the application be made to the whole uterine canal, or to the cervix alone, it must be remembered that the more powerful the caustic the longer will it be before the slough separates; that of nitric acid usually takes from five to seven days; that of iodized phenol, or pure carbolic acid, three to four days; that of tincture of iodine,

two days. Not until the slough has separated should a second application of a milder nature be made. I usually employ a solution of nitrate of silver, one drachm to one ounce, or tincture of iodine, and continue these applications every other day, or twice a week, until the raw surface is glazed over, or a return of the discharge shows that the severe treatment has not been effectual and requires to be repeated wholly or in part. It should be remembered, however, that so long as constant applications of caustic are made to a raw surface, it cannot heal. Hence it is well, after a couple of weeks of steady treatment, to allow the patient a week's rest, in order to give nature a chance to heal the wound; if she then fails we must begin again, and perhaps a third and a fourth time.

That *hot* injections should be steadily used whenever there are no tumors in the vagina need scarcely be mentioned. The vaginal leucorrhœa usually present is very effectually controlled by painting the canal through a cylindrical speculum with a mixture of fluid extract of hydrastis canadensis and glycerine, equal parts, and placing a couple of tampons, soaked in this fluid, into the vagina, to be removed in twenty-four hours. As an injection, a tablespoonful of the plain fluid extract of hydrastis in a pint of water is excellent to continue the more powerful effect of the application just mentioned. I have found this remedy superior to any other astringent in vaginal leucorrhœa, as it can be used undiluted without cauterizing or eroding the vagina or vulva.

Patients with chronic endometritis or endocervicitis should be treated at least twice a week, and usually every other day. The more chronic and aggravated the case the more frequent the treatment. As improvement manifests itself,

intermissions of several days, or a week or two, may be made, in order to test the persistence of the benefit.

I have not referred to the time-honored practice of dilating the uterus with a sponge-tent, and tearing away the hyperplastic glands and mucous membrane when the tent is removed, because the dilatation is more safely accomplished by the tupelo, and the removal of the diseased tissues more thoroughly by the sharp curette. But, when the uterus is unusually enlarged and a decided drastic and alterative effect is desired, the sponge-tent may still be employed and prove beneficial. The usual caustics should follow its application. The forcible dilatation of the whole uterine canal by steel divergent dilators or graduated sounds has proved exceedingly useful in my hands in this disease. Not only does the dilatation allow the easy application of topical agents, but the free exit of fluids and the steady pressure of the dilators in themselves act beneficially on the diseased tissues.

*The prognosis as regards permanent cure* will always be a doubtful one, so long as some time has not been allowed to elapse since the discharge of the apparently cured patient. A temporary improvement, or even an entire cessation of the discharge, may, in a few weeks or months, be followed by a fresh attack of the disease. This experience is common to chronic catarrhal affections of all mucous membranes. And only by means of constant, unremitting and long-protracted treatment can a permanent improvement or a CURE be obtained. My experience certainly has furnished me with a fair proportion of cases in which, after several months of the treatment above described, an improvement was obtained of such duration as to leave the patients entirely free from uterine discharge for three and six

months. Whether the cure was really permanent afterward, I am unable to say, as such patients who came from a distance were lost sight of; of those living in the city, I infer a permanent cure, since it is fair to suppose that, having once been benefited, they would have returned to me had the disease recurred.

Those cases I have found the most amenable to treatment and the most favorable for a permanent cure, in which the uterine discharge was chiefly maintained by a narrow external or internal os, or where a laceration of the cervix and consequent hyperplasia of the follicles was present. The radical operations for these conditions, as I have described them (removal of diseased glands and papillæ by the curette and caustics, division of the external and internal orifices, and, in given cases, closure of the laceration), usually secured a permanent cure. The most obstinate were those instances of catarrhal endometritis and endocervicitis, in which the external and internal orifices were anatomically normal, and no special hyperplasia of the glands or mucous membrane could be detected. Here all efforts to rest on the normal secreting qualities of the mucous membrane usually proved unavailing and permanent relief seemed hopeless. Where there was a distinct pathological condition or lesion of the orifices or tissues of the uterine canal, the removal of that condition and the restoration of the canal and its walls to the normal state was generally possible, and a permanent cure could with fair certainty be promised. My experience, at all events, does not coincide with that expressed by the words of one of our most eminent gynecologists when giving his opinion on two cases of sterility depending on chronic uterine catarrh (one endometritis, the other en-

docervicitis) which recently consulted him, viz.: "This is an instance of that interminable uterine catarrh, which is practically incurable." Both these cases came to me utterly discouraged, and after three months of the treatment here described were discharged, to all appearance cured, having been free from discharge for one month without treatment. Whether they remain so is, of course, another matter. But they were both certainly relieved long enough to give them a chance to conceive, and if this happy event should take place, nature alone could, during the puerperal state, complete the cure. And if this one attempt at relief fails, and after some months the discharge returns, as all catarrhs are liable to do, better success might attend a second course of treatment. It certainly does not seem right to discourage all such patients and deprive them of all hopes of maternity (should they chance to be nulliparæ) when experience has shown us how much good a thorough, persevering course of local treatment will do them.

In making this statement I wish to except that class of cases which have been made a special study by Dr. Noeggerath, viz., latent gonorrhœa in the female, where catarrhal infection (I would like to call it affection, for I do not believe in the frequent venereal transmission of this disease as warmly advocated by Dr. Noeggerath) of the vagina and uterine canal has spread to the tubes, and has thus planted itself beyond the reach of topical, as well as general, medication. These cases, when once chronic, are really incurable, and, if they recover, do so almost in spite of, not in consequence of, treatment. Fortunately these cases are not the majority of those which come under our observation. For them only the last resort of Tait's brilliant operation—the removal

of the diseased tubes, generally with the ovaries—remains. And we look forward to the not far distant day when we in this country can point to results as favorable after this operation as those reported by its originator.

The intelligent specialist and the general practitioner need scarcely be told that accompanying anæmia must be suitably treated. The influence of iron and other tonics is as marked in improving the tone and functional power of the uterine mucous membrane as of any other organ of the body. Pelvic plethora should be relieved by saline laxatives, the general circulation stimulated and regulated by massage and active exercise, and active hyperæmia of the sexual organs prevented by abstinence from sexual intercourse, during the local treatment here described. And it certainly must be a desperate case which resists all these measures.

[This heroic treatment has been thoroughly tried, and the results have not been better than that obtained by more conservative means. The only thing original which has been brought forward within the past few years in the treatment of cervical endometritis will be found in the transactions of the American Gynecological Society, vol. 4, by Dr. Battey, of Rome, Georgia. We have given Dr. B.'s method a fair trial, and have succeeded better with it than with the older methods mentioned in Dr. Mundè's paper.]

A. J. C. S.

#### **Soluble Stools after Perineorrhaphy.**

At a recent meeting of the Obstetrical Society of Philadelphia (reported in the *Medical & Surgical Reporter*), Dr. WM. GOODELL reported a case on which he had operated for the relief of lacerated perineum, upon an insane woman, who had been sent to him for that purpose

from an asylum. Her insanity commenced after labor, and was probably due to a complete laceration of the perineum, extending two inches up the rectum. It had always been his habit to prevent any action of the bowels during the first week after the operation. This patient, soon after coming out from the influence of the anæsthetic, tore off the bandage from her knees, removed the catheter, and by severe straining efforts secured a movement from the bowels. As she could not be controlled, laxatives were given to secure liquid stools and avoid straining. The patient walked freely about the ward from the day of operation. The doctor expected the operation to be a failure under such circumstances, but to his surprise, on removing the sutures, he found that in the rectal portion and the important part of the perineum, union had taken place.

His attention has been called by this case to the question of the advisability of keeping the bowels constipated after this operation. He intends to try the effect of laxatives in future cases.

Dr. R. P. Harris reported the case of a woman who, after the operation of perineorrhaphy, would strain, and her efforts at defecation opened the wound to nearly its original extent. In a second operation on the same patient, the bowels were kept free and union was perfect.

Dr. E. E. Montgomery, after operating for lacerated perineum, does not use a catheter, but allows the patient to pass her water, as he does not consider healthy urine disadvantageous for a wound. He has been in the habit of using compound liquorice powder to keep the stools liquid. He has had good success in both primary and secondary operations upon the perineum where the rectum was involved.—*Med. Age.*

**Uterine Movements.**

In formulating the results of a large number of experiments made upon rabbits, Dr. FROMMEL states that the uterus undergoes regular rhythmical contractions. These contractions occur in all stages of uterine development, though they are more regular in pregnant animals or in those which have previously borne young. The movements are slowed by a low temperature, and quickened by a slightly increased one; but a high temperature (103° F. or more) abolishes them. Circulatory disturbances exert a marked influence upon the contractions. Compression of the aorta causes them to cease within a very short time; that of the vena cava produces the same effect after a longer period (fifteen to thirty minutes). The author states that the uterine contractions are independent of any nervous centre situated without the organ itself, though, of course, they may be modified by impulses received from the cerebro-spinal centres.—*Centralblatt für Gynäkologie.—Med. Record.*

**DISEASES OF CHILDREN.****Earache in Children.**

Dr. SAMUEL SEXTON thus closes an interesting article on the treatment of this affection (*Med. Record*): The desire to relieve pain in these cases generally leaves prospective measures to be last considered, and, indeed, the surgeon will usually find that local measures have been already carried to excess. It will by no means always be easy to proceed at once to make the necessary examination upon which a plan of rational treatment may be founded, where there are a number of anxious attendants who have already emptied into the sufferer's

ear everything their resources could command before availing themselves of skilled counsel. It will usually be expected that the means at the command of the medical adviser will enable him to propitiate the disturbing spirit by the contribution of some new libation, unknown to common mortals; this requirement may be met where the condition of the canal admits of deep applications being made. A remedy that will in some instances be found serviceable for this purpose is belladonna; the deeper parts may be painted over with a small quantity of a mixture composed of equal parts of unguentum belladonnæ and vaseline, or four drops of a five-grain solution of the alkaloid sulphate of atropine may be instilled into the up-turned ear by the surgeon himself, who can alone apply these remedies properly. They should be warmed before being used, and, it is needless to say, should not be wasted upon the outer portion of the canal. Of course it would be useless to make these applications when the canal was not free of secretions. In a certain number of cases this medication will be found to be an efficient palliative, as in periostitis of the inner extremity of the canal, as shown by redness and swelling, and when the membrana tympana is inflamed; any considerable effect on the nerves more deeply situated in the tympanum is, however, not to be expected, unless, as might exceptionally happen, a few drops of the solution passed into the middle ear through a perforation in the drumhead.

Dry warmth, when grateful, may be applied, either as heated air conducted into the ear, or by means of heated pillows, etc. In some instances gentle fomentations or steaming may be employed, but active syringing, douching, steaming, poulticing, or even mopping out the canal, are all of them to be specially

avoided, as they usually do more harm than good, and in very many instances are positively injurious.

*Myringotomy.*—Sometimes there is no discharge from the inflamed parts, and then the question of puncturing the drum-head arises. In regard to the necessity of this operation there has been much discussion among otologists, some authorities favoring its performance in nearly all cases, especially when the membrana tympani is much inflamed or is perceptibly protruded by the pressure of secretions. It is a matter, I believe, where a great deal of judgment is often required to be exercised, more, in fact, than is generally thought necessary. In my own experience I have found that a bulging or much-inflamed drum-head by no means always demands this procedure for the relief of the patient, for I have often found that under other treatment the pains and other inflammatory symptoms will speedily subside; secretions will be re absorbed or partly escape through the Eustachian tube, the membrane will rapidly clear up, and all the parts assume a healthy appearance.

But occasionally the membrana tympani will be found to have been much toughened by previous acute or chronic inflammation, or the existing attack may have occasioned thickening of its inner mucous or outer cutaneous coat. If now it is found that there is undue and painful pressure of secretions whose escape is prevented by closure of the Eustachian tube, we shall be warranted in liberating them by means of myringotomy. But this operation is not always unattended by considerable pain, and, moreover, if well performed, not to be done without skill, and we should not, I am convinced, resort to it as a mere antiphlogistic measure, with the belief that, even if useless, it is at all events harmless. When the parts to be

operated on are not well seen, the procedure is at best an unskilful stab, the consequences of which are not always favorable. When myringotomy is necessary, however, it should be promptly done, and usually while the patient is under the influence of an anæsthetic.

*The employment of leeches* in my own experience has not been satisfactory, and I have for a long time past ceased to use them. I am aware that custom still demands the use of these sanguinary worms in certain quarters, but I doubt not their usefulness has been much overestimated.

The remote abstraction of blood from the cheek in front of the tragus or, even from the concha, will not permanently relieve congestion of the deeper parts; and, moreover, it is not the stagnant blood that is withdrawn, but the more freely circulating fluid. In a certain number of cases, the bite of the leech seems to give rise to irritation, and what wonder that it does when we consider that its mouth, according to Baird, is provided with three jaws, and "each of these is armed on its edge with two rows of very fine teeth, which penetrate the skin by a motion resembling that of a semicircular saw." Besides the irritation from the bite, their appearance is calculated to frighten the child, and oftentimes the bleeding is arrested with difficulty.

Among the more valuable drugs which are serviceable in earache from any cause in which nervous excitability is a feature, I know of none equal to aconite, gelsemium, or pulsatilla, five or ten drops being added to half a glassful of water, and given in teaspoonful doses as required.

In my own experience the relative efficacy of these remedies has been found to be about in the order mentioned above. In very young children,

I give the preference to the pulsatilla. It is important in employing these drugs to secure a tincture made from the fresh plant.

The sulphurated lime, which I have long employed in affections of the ear, I still regard as of the greatest service. I have scarcely ever seen a case where this medicine produced nausea, although some persons who have given it a trial claim to have had an experience of this kind. I have so often described my own experience in the use of this drug that I will not repeat myself here. When the subject is too young to admit of the administration of pills, triturations may be employed.

No plan of treatment would be entirely satisfactory where an examination of the mouth and upper pharynx was neglected. Oral irritation may thus be found to consist in the eruption of teeth, caries of the teeth, irregularities, tartar, irritation from catarrh of the gums, periostitis and alveolar abscesses. The frequency of the occurrence of these conditions has been mentioned above; they require treatment and likewise often the assistance of the dentist. Under treatment the worst agonies of earache may be prevented, and very often our remedies act like a charm; but it must not be forgotten that the causes in a given case may not be so easily eradicated, and that treatment must be kept up for some time if we would entirely prevent a return of this tormenting disease. Catarrh and other affections of the naso-pharynx and Eustachian tubes also require like care, and sometimes must be treated actively.

The advantages of rest in acute purulent inflammation of the middle ear should never be lost sight of, and the patient should be kept indoors for several days. If the case be a severe one, he will be best off in bed for a time.

Quiet ought to be maintained in all cases, for noises sometimes under these circumstances become exceedingly distressing. The evils of active treatment in these cases, by syringing, etc., have been alluded to, and it may here be urged that deafness as a symptom should not be treated; especially should inflation be avoided; the patient is to be cautioned even against violently blowing the nose. Of course in the later stages syringing and mopping may be more thoroughly practised and the cautious use of the air-douche may even be advisable. The well-known tendency of some drugs to cause or increase existing aural hyperæmia should warn us to avoid their indiscriminate use. First among these is quinine, which has long been suspected of causing deafness when administered in large doses in malarious diseases. The intense tinnitus aurium following its administration establishes the fact of an increased vascular action in and about the ear. The employment of ferruginous preparations seem to have a like effect, and doubtless there are many others which it were best to omit when the ear is inflamed.

During the existence of acute aural disease, the consequences of its early management upon the subsequent course and duration should be kept in mind, but the consideration of chronic processes here would lead me beyond the scope of the present paper, which has, I fear, already been unduly drawn out.

#### **Eclampsia Nutans.**

Dr. GANTIEZ relates a case of salaam convulsions which he witnessed in a child, seventeen months old. The attacks were preceded by a period, varying from a few seconds to a minute, during which the child presented an absorbed air, seeming to be a little ap-

prehensive, but not agitated. The eyes were raised and fixed, and there was a little pallor. Then suddenly any toy that was in the hand was cast away, the head was flexed upon the thorax and the trunk upon the pelvis. At the same time the shoulders were slightly raised and the arms thrown forward with the hands extended, as if to prevent a fall. These movements followed each other with great rapidity, sometimes as often as thirty times in succession, but usually only eight or ten times. After the attack the eyes were filled with tears, and there was an expression of astonishment upon the child's countenance. He was easily comforted and soon resumed his play. The attacks occurred about eight times a day, and since they began, at the age of nine months, had never missed a day. Bromide of potassium had failed to exert any controlling influence over the disease.—*Revue Médicale*.—*Med. Record*.

#### How to Administer Santonin.

The *Med. Press* say that Herr L. LEWIN, in a recent paper on the above subject, read before the Medical Society of Berlin, finds fault with all the usual methods of administering santonin. According to his views, it should be given in its least soluble form, *i. e.*, in the form in which it will be the least readily absorbed, as the effect desired is not a general, but a local one. An oily solution of santonin undergoes, according to his experiments performed on animals, not the slightest absorption in the stomach, so that under no circumstances is any trace found in the urine. Almost any kind of oil may be employed, coconut oil, olive oil, cod-liver oil, or castor oil. He recommends that 0.2 gm. (3 grs.) of santonin be mixed with 60 gm. (2 oz. *cir.*) of oil and given in four doses. He thinks that a useful ad-

dition to the above would be that of an oil contained in santonica, the oleum cinæ, æther., for the reason that all æthereal oils have been shown to act as poisons on the lower forms of animal life.—*Med. Times*.

#### Castor-Oil and Glycerine.

A mixture, which is of an agreeable flavor and in which the nauseous smell of the oil is efficiently disguised, can be made thus:  $\mathcal{R}$  Ol. ricini,  $\mathfrak{z}$  j.; glycerini,  $\mathfrak{z}$  j.; tr. aurantii,  $\mathfrak{M}$ xx.; tr. senegæ,  $\mathfrak{M}$ v.; aquæ, cinnam, ad.  $\mathfrak{z}$  ss. This forms a beautiful emulsion, is easily taken, even by children, and if administered at bedtime will produce a gentle motion the following morning.—*N. Y. Med. Journal*.

#### Tuberculosis in Infants.

Dr. J. LEWIS SMITH, in *Med. Record*, thus speaks of his treatment of this disease:

Whenever, therefore, I am called to a young child with a chronic cough and wasting, I do not wait for a more accurate diagnosis, but if there be no diarrhœa to contra-indicate it, prescribe cod-liver oil with the hypophosphites, frequently adding the syrup of the iodide of iron, since the strumous cachexia is so apt to be present with probably caseous substance, in some part. Such a case requires the utmost attention to the hygienic management, pure air, nutritious, and easily digested diet, into which milk enters largely, the juice of meat or meat-broths, prepared at a temperature of 100°, so as not to coagulate the albumen. A favorite prescription in two of the asylums of this city for these infants with chronic cough and wasting, whether or not tuberculosis be diagnosticated, is the following, to be taken between the doses

of cod-liver oil : R Ammon. carbonat., ferri et ammon. citrat., āā. gr. xxiv. ; syrupi simplici, ℥ iij. M. Dose, one tea-spoonful every two or three hours to a child of one year.

#### Chloroform Breath in Gastric Disturbance.

There is a symptom of gastric disturbance in children which I have never yet seen mentioned in any text-book, French or English, and yet it is almost invariably constant and generally to be met with at the *début* of the affection, so that it may be considered as a sure premonitory sign, I mean that of the breath, which smells as if the child had freely inhaled chloroform. I have always found that this "chloroform breath" not only commenced with the gastric disturbance, but continued during the whole period of the malady, and that its cessation indicated also a cessation in all the other general symptoms, fever, vomiting, etc., and consequently a return to health. I have remarked this peculiar odor in children of every age, and once in a grown-up person; it was then very strongly marked. I do not pretend to be bringing to light anything new, but I have never heard this peculiar symptom alluded to anywhere.—*Med. Press and Circular*.

#### Bromic Ether in Whooping-Cough.

Dr. SQUIRE recommends a solution of bromic ether in water (1 to 200) for administration in whooping-cough, as well as for angina pectoris and spasmodic pain.—*Med. Record*.

#### Activity of the Senses in New Born Infants.

GENZMER, in a second edition of his inaugural dissertation (*Centralbl. fuer die Med. Wiss.*), says that the sense of

touch is developed from the earliest period, and reflex actions are readily excited by the slightest stimulation of the nerves of touch, especially of the face, then of the hands, and soles of the feet. The feeling of pain is but slowly developed, and is only clearly exhibited after four or five weeks, before which time infants do not shed tears. True muscular sense is at least doubtful. Excitement of the sense of touch gives rise to unconscious reflex movements; the amount, therefore, rather than the quality of the sensation, is observable. Closure of the nostrils occasions a reflex dyspnœa. Hunger and thirst are manifested in an increased general irritability, followed by reflex movements; these cease after the first week. Smell and taste are not distinguishable in infants. Genzmer asserts, in opposition to Kussmaul, that the sense of hearing is perceptible in the first, or at most the second day of life. New-born infants are so sensitive to light that they will turn the head to follow a mild light, whilst if a strong glare be suddenly thrown upon the eye, squinting is induced, and even convulsive closure of the lids. After a few days, the child will follow the motion of various objects by movements of its head. Between the fourth and fifth weeks the convergence of the pupils and the power of coördination in vision are perceptible. A distinct perception of color does not exist under four or five months; before then it is quantity rather than quality of light that is recognized. The inhibitory reflex centre is not yet developed in the eye; weak and moderately strong irritation excite movements which subserve that purpose. Excessively strong impressions only excite passive movements. New-born infants cannot separate the impressions on their organs of sense. The readiness of excitability is shown in the fact

that the stronger the stimulation the shorter the physiological interval.—*London Med. Red.*

**For Spasmodic Affections of the Respiratory Tract in Children.—Simon.**

R̄ Tinct. belladonna; tinct. aconit. rad., aa. *M* 75; vin. opii, *M* 75. M. 3 drops morning and evening, increasing the dose by one drop daily.—*L' Union Medicale du Canada.*

**OBSTETRICS.**

**Adherent Placenta.—Efficient Galactagogue.—Infantile Menstruation.**

A. H. P. LEUF, M. D., Brooklyn, N.Y.:

Female; married; æt. 23 years; spare build; average height; anæmic; dark complexion; third pregnancy.

Labor-pains began August 12, 1882, at 3 A. M. Was called in at 7.45 A. M. Patient suffered very much from inefficient pains. She begged for chloroform, and it was given her very moderately. Fœtus in first position; born at 8.45 A. M., labor having lasted five and three-quarter hours. Body of child was expelled three minutes after birth of head by "*expressio fœtus*." Gave 3 ss. of liquor ergotæ when head was born, followed by another 3 ss., in hot water, in twenty minutes. Continuous abdominal pressure and massage was used to maintain firm uterine contraction. Attempted to extract the placenta with the hand after waiting fifty minutes. Had to desist on account of intolerant pain. Waited ten minutes more, and then gave chloroform with nitrite of amyl, and, when under, rapidly extracted the placenta. It was found firmly adherent to the right side of the fundus uteri to the extent of about 5 c. m. in diameter. The adhesion was so

firm that the placenta was perforated in several places by the fingers while removing it from its attachment. Immediately after the complete extraction of the placenta the uterus contracted firmly and permanently. Gave liquor ergotæ gtt. x t. i. d. for two days, and then reduced it one-half for two days more, after which its use was discontinued. There was also no lacteal secretion. Mammæ were flaccid. Ordered milk (diluted) by the bottle for the baby. Next day (13th) was told that mother did not feel well and had little appetite. Still no milk. Baby had cried almost all night. Its stools were hard and dry and of a dark green color. They were accompanied with pain. Bellyache was almost constant. "Baby almost doubled up at times." Vomited in curds almost all the milk it had taken. Ordered mother to take a tumbler of good fresh milk every second hour and to eat any kind of good food she wished whenever she became hungry. Broiled beefsteak was especially recommended. She was also directed to frequently apply to the breasts some cloths that had been dipped in warm, but not hot, water. The baby was to be put to the breast every two hours, alternating with the milk the mother had to take. After being at the breast for awhile the baby was to get some cow's milk and lime-water from a bottle until satisfied. The baby was nursed and fed not oftener than three times at night.

Next day (14th) baby's bad symptoms had all disappeared. Mother's breasts were very full of milk. It had been necessary to use the bottle only three times. Ever afterward all was well and improving. At the previous two pregnancies mother's milk did not appear until nearly one week after parturition, and then only very scant. Never had enough for other two babies.

Always had plenty for last one. On the 16th, early in the morning, a bloody discharge was noticed coming from the *child's* vagina. This increased for twenty-four hours, and then began to decrease, and stopped at the end of another twenty-four hours. At first it consisted of small dark blood clots. Later it was brighter in color. It was at all times mixed with mucous. The vulva appeared perfectly normal. Hymen was absent. Vulvo-vaginal orifice was about 1 c. m. in diameter, easily admitting the end of my little finger. Inward pressure of the opened vulva would cause a few drops of blood and mucous to exude from the vagina. Not the slightest constitutional disturbance was noticeable at any time. I saw this case about five months later, and was told that the bloody discharge had never reappeared.

This case was undoubtedly one of adherent placenta. It demonstrates the utility of giving large quantities of good milk at regular intervals, associated with the frequent application of moist warmth (not heat) to the mammæ, for the purpose of bringing on and maintaining an abundant secretion of milk. It also presents a case of so-called infantile menstruation, which was simply an intense vaginitis; or better still, during birth, a quantity of blood was pressed into the infantile vagina from the maternal passages and regurgitated only after several days.

#### Cystitis.

Dr. W. J. OTIS, of Boston, reports the case (*Boston Medical and Surgical Journal*) of a primipara, aged twenty-six, whose perinæum was lacerated during labor. Her urine showed albumen, and granular and hyaline casts. She had to be catheterized every day. After a week symptoms of cystitis developed, not marked enough to call for special

treatment. Nearly five weeks after her delivery he was called twice to see her on account of retention and suffering. At the second visit, in attempting to pass the catheter, he could not insert it into the meatus. Upon examination a mass of slough was found presenting. On tearing it away urine came with a gush. Examination of the mass showed two irregular pieces of the interior coat of the bladder, which had evidently sloughed off.

Query :—Was the cystitis set up by a catheter insufficiently cleaned carrying in some septic germs?

[Very possibly. An unclean instrument and mechanical violence, especially when combined, are competent, and doubtless not infrequent causes of cystitis in childbed. The following precautions may do much to prevent this complication :

1. Use a soft-rubber catheter.
2. After using lay it, well cleansed, in a 3 per cent. carbolic solution till wanted again.
3. Carefully cleanse the approaches to the meatus before passing the catheter.]

J.

#### The Subcutaneous Injection of Ether.

M. HAYEM, Professor at the Paris Faculty of Medicine, in a communication recently made to the Academy of Medicine, on the utility of hypodermic injections of ether when death from hemorrhage is imminent, asserts (*Gaillard's Medical Journal*) that injections of ether practiced on a dog which had lost so much blood as to have tetanic convulsions, and to be on the point of death, was followed by no perceptible results. In a similar case, transfusion of blood containing all its constituent parts was followed by, as it were, a veritable resurrection. When a sufficient quantity of blood (one nineteenth of the

weight of the body) is removed from the animal, to place it just on the boundary between imminent death and possible survival, the result of subcutaneous injections of ether is equally negative. In the same circumstances, not only is transfusion of blood successful, but even, in some cases, recovery ensues, when the blood still remaining in the organism of the animal is diluted with serum taken from another animal of the same species. M. Hayem is of opinion that these facts indicate that it is a mistake to affirm that transfusion is a useless operation, and that the stimulation produced by hypodermic injections of ether can be substituted for it. Stimulation by ether, he remarks, increases the force of the cardiac contractions, and quickens the heart-beats in a remarkable manner, but it does not increase blood pressure, nor raise the temperature in the rectum.—*Med. Age.*

[The possible value of an intravenous injection of a solution of common salt should not be lost sight of in the emergency which calls for transfusion. This fluid is always available, is safer than the transfusion of blood and requires less skill and simpler apparatus for its use. The only outfit needed is a glass funnel, a few feet of rubber tubing and a canula improvised from a bit of glass tube. The solution should be of six per cent. strength, and made with boiled water. It should be rendered slightly alkaline by the addition of a few drops of liquor potassæ, should be filtered and slowly injected at the temperature of 100° F. The volume may be from one to two pints. The writer of this note has found a drachm of liquor ammonia a useful ingredient in this solution.] J.

#### Sign of Pregnancy.

JORISENNE has furnished a sign (*American Journal of Obstetrics*) by

which we can diagnose pregnancy during the first two months. Starting with the assumption that in pregnancy there is a hypertrophy of the heart (and this assumption, if erroneous, will not affect Jorissenne's results), he has found that, while in health there is a variation of ten to twenty beats in the radial pulsation, according as the body is upright or horizontal, in pregnancy, no matter what the position, the beats number the same. Jorissenne has been able to diagnose pregnancy as early as the first month, when no other sign except the missing of a menstrual period was present. When examining a patient for this sign, it is necessary to proceed with deliberation, first counting the radial for a space of fifteen seconds while the patient is standing, then sitting, then reclining. The order may then be reversed, and uniformly the same number of beats will be recorded. Jorissenne promises an explanation of this phenomenon in a future paper.—*Weekly Med. Review.*

#### Asafœtida in the Treatment of Abortion.

In the *Journal de Médecine de Paris* are collected the results obtained by several observers in the prevention of abortion and premature labor by asafœtida. Dr. LAFERLA, acting upon the theory that the death of the fœtus was owing to an asthenic condition of the uterus, administered the drug in a number of instances. In nearly ninety per cent. of the cases so treated the patients (who had aborted from two to five times in former pregnancies) went on to full term. Drs. Giordano and Carzani announce equally favorable results, though the number of their cases was smaller. The latter prescribes the drug in pill form in doses of one and a half grain twice a day, gradually increased to twelve grains per diem. Dr. Gourgnès recommends the administration of asa-

foetida, in emulsion with the yolk of an egg, by the rectum.—*Med. Record.*

#### Transfusion of Pure Water.

Dr. COATES (*London Lancet*) reports a case of transfusion of pure water, warmed to the proper degree. The patient was a primipara, twenty-seven years of age. The cause of collapse was an alarming hemorrhage on the ninth day after child-birth. Some twenty-two ounces of water were allowed to enter the median cephalic vein through a Jennings siphon. The result was striking, and convalescence speedy.—*Ibid.*

#### Parturition Complicated with Whooping-Cough and Pleurisy.

In the *Edinburgh Medical Journal*, Dr. WM. J. BEATTY reports the case of a woman who, being pregnant, contracted whooping-cough from her children, three weeks prior to the expected confinement. On the night before labor commenced, she was seized with pleurisy. As soon as delivery was effected, she commenced to improve, and was entirely well eleven days after confinement. The Doctor, in conclusion, says: "This case caused me much anxiety, as the complications were really very formidable, and I confess I was rather surprised to find my patient recover so rapidly. Perhaps the pleurisy was cut short by the usual 'loss' after childbirth, and, if so, are we right in not bleeding our patients in inflammation of the lungs or their serous envelope? Strange, too, that she lost her whoop."—*Med. and Surg. Reporter.*

#### Induced Premature Labor Necessitated by Great Œdema of the Labia Minora.

Dr. H. WILLARD reported before the Philadelphia Obstet. Society the following case:

The patient, probably over 40 years of age, had been married about one year, and was pregnant with her first child. She suffered from headache, her feet and eyelids were swollen, and her urine showed one-sixth albumen and contained casts and blood-corpuscles. Basham's mixture, diuretics of every kind, diaphoretics, hot-air baths, hydragogue cathartics, and tonics were used, without a satisfactory result. Digitalis infusion and jaborandi alone gave a very temporary relief. The patient soon after her first visit called attention to the condition of the labia minora, which were found to be enormously swollen, shining, tense, and pitting on pressure. The urine amounted to from fifteen to thirty ounces per day, and steadily decreased in quantity. The œdema of other portions of the body decreased under the use of digitalis, but that of the labia increased. The patient could lie only upon her back, with the knees drawn up and as widely extended as possible; the pain was great and constant. Lancet-punctures were made, with temporary relief. The patient was steadily failing; her pulse was 150 per minute. An erysipelatous blush made its appearance and rapidly spread to the abdomen and thighs. Premature extraction of the child offered the only chance, and was at once performed. Gestation had reached eight months. It was a difficult task, as the labia were five inches in depth. Barnes' dilators and the Hodge forceps were used, and delivery accomplished in two hours. The child was dead, and the mother died three hours later.—*Ibid.*

#### Dangerous Hemorrhage from External Genitals during Labor.

Dr. PETER YOUNG calls attention in the *Med. Press* to a case in which there was persistent bleeding after the deliv-

ery of both child and placenta. Notwithstanding the vigorous application of the usual restoratives, the woman died in a few minutes, and before arrangements could be made to perform transfusion.

On post-mortem examination the source of bleeding was found to be a tear at the upper margin of the vulvar orifice, extending from the left side of the urethra up towards the clitoris. Numerous venous sinuses and two or three small arteries were lacerated.—*Med. and Surg. Reporter.*

#### Instructions to German Midwives.

The following is from the *Medical Press and Circular*:

1. Medical science has, for a number of years past, arrived at the fixed conviction that the great majority of cases of childbed fever depend for their origin upon the inoculation of recent wounds (produced more or less in every case of labor) by putrid (so-called septic) poisons.

2. These poisons readily cling—but in an imperceptible manner—to every kind of utensil that may come into contact with the woman in labor, unless they are kept scrupulously clean.

3. But it is the hands and instruments of the obstetrician that have become known to be especially dangerous bearers and disseminators of the poisons, as it is impossible to avoid bringing these into contact with dangerous putrefying material.

4. Simple, and even repeated, washings with soap and water, as observation has shown, will not remove the poisons that may be clinging to the hands and instruments. The slightest trace of such poison will, however, suffice to set up the gravest—yea, even fatal—childbed fever.

5. Wherefore it is the most sacred duty

of every midwife, as of every physician, *in other ways*, so thoroughly to cleanse the hands and instruments, and whatever other appliances may be brought into contact with the patient, that she may not be inoculated by any poisonous matter.

6. We are able, as we learn by observation, to destroy the poison, or, at least, render it powerless, by boiling water, and especially by the stronger solutions of carbolic acid (two to five per cent.).

7. The simple rinsing of the hands in carbolized solutions that are too weak can afford no protection against childbed fever.—*Ibid.*

#### Prolonged Use of Chloroform in Labor.

Dr. J. WYBRANTS OLPHERTS, in the *British Medical Journal*, relates a case of instrumental labor, in which the woman was kept completely under the influence of chloroform for over six hours, during which time the forceps were applied, craniotomy was performed, and the forceps used a second time. There was no excessive post-partum hemorrhage, no vomiting, no nervous shock. These good results he attributes largely to the use of chloroform, for he fears that ether would have a greater tendency to produce these troubles.—*Ibid.*

#### Treatment of Puerperal Sepsis.

In a recent paper on this subject by Dr. FISCHER the value of local treatment is especially insisted upon (*Archiv für Gynaekologie; Deutsche Med. Zeitung*). For all abrasions or ulcerated surfaces discovered by the speculum examination, potassium permanganate solution and tincture of iodine, or solution of chloride of zinc are used; and subsequently irrigations of uterus and vagina with antiseptic solutions are required. Since the introduction of this method into the practice of the Prague clinic it has been claimed that its mortality rate is better than that of any other German clinic.—*Med. Times.*

## DISEASES OF WOMEN.

## Vaginismus. Its Treatment.

Dr. W. C. PEASLEE (*Weekly Med. Review*):

To treat this disease in a manner that will be tolerated by the patient, often taxes the inventive faculties of the physician to their utmost capacity, and in many cases patients will not submit a second time to the painful treatment which we ordinarily adopt. Recently cases have come to me for treatment who had been under the care of several other physicians, but the means adopted in each case produced such unbearable suffering, that after several attempts the patients absolutely refused to receive further treatment, which consisted mainly in the introduction and prolonged use of a speculum. This always induced severe and very painful contractions of the sphincter vaginae muscles upon the speculum, producing a very telling effect upon those muscles, which, I think, are of secondary importance in the treatment. Believing, as I do, that the pathological condition exists principally in the mucous membrane of the vulva and vaginal orifice, which, when irritated, is followed by contraction of the sphincter muscles (as occurs in closure of the eyelids from irritation of its lashes, or spasm of anal sphincter from ulcer or fissure), I directed my efforts entirely toward that membrane. To do away with the suffering incident to the contractions of the sphincters upon an unyielding speculum, I use a large sponge tent, which I prepare by passing a piece of small rubber tubing eight or ten inches long, or a catheter (in which I insert a piece of wire to prevent compressing the tube when winding the tent) through a cone-shaped sponge, over which apply a layer

of strong twine compressing the sponge as closely as possible, then lay aside, and when dry insert the tent into a rubber condom (to prevent sponge from penetrating the mucous membrane), fastening the open end of condom firmly around the rubber tube. Lubricate and insert, except about one-half to three-fourths of an inch, which is left external to sphincter for the purpose of pressing against the vulvar portion of the mucous membrane; then attach a syringe (containing from one-half to one ounce of warm water) to the rubber tube and inject the contents, which will be carried to the internal end of tent, causing it to expand first, which aids materially in its retention. Remove syringe and tie the tube or insert a plug to retain the water; then apply patient's periodical bandage, and after she has remained in recumbent position about half an hour, permit her to get up and go about the house, allowing tent to remain as long as forty-eight hours, if borne well.

This method of treatment affords a very effectual means of overcoming the disease without confining our patients to their beds, and without much suffering, as the sponge readily yields to the contractions of the muscles, yet is sufficiently elastic to exert a firm pressure upon the mucous membrane of the vulva and vagina. I believe this sponge tent fully as efficacious as the Barnes bag, and much more acceptable to the patient, since the sponge is more readily compressed. The results which I have obtained are so satisfactory that I am convinced if this treatment is properly carried out we need scarcely ever resort to the division of nerves. A case or two may not be inappropriate here:

Dr. J. R. (initials borrowed) having previously consulted me concerning his wife, brought her before me January 5.

1882. She had suffered much from occasional attacks of neuralgia. Is of gouty diathesis, twenty-five years of age, has been married three years, and had never had intercourse, she being so sensitive as not to tolerate the slightest touch of anything to the vulvar mucus membrane; had resisted all his arguments for operative treatment. On examination I found two large vascular excrescences protruding from the orifice of the urethra; also several carunculæ around margin of vagina, which I considered the prime factor in this case, but finding I could not persuade the patient to submit to operative interference for their removal, I made an appointment with them, and on the following day inserted a sponge tent, which the patient retained for two hours with but little inconvenience. I inserted another the following day, which she retained eleven hours. After the use of seven tents, the doctor reported a perfect cure.

February 27, 1883, Mrs. M. B., aged twenty-four; slight build; been married two and a half years, and bearing every evidence of sexual starvation, her health having failed rapidly during her married life. She stated she had not been able to have intercourse with her husband on account of being so tender and sensitive. An examination verified her statement, and disclosed the presence of a severe leucorrhœa, an abundant discharge of viscid mucus, which led me to suspect uterine trouble. I attempted to use the speculum, but she could not tolerate it. I ordered hot vaginal injections for that evening and next morning, at which time I inserted a small tent, which by its gradual distention was borne four and a half hours quite well. I prescribed nerve tonics, and by the use of five tents gradually increased in size, she completely recovered.

[We have had good success in treating vaginismus by overdistingending introitus vulvæ. The patient is anæsthetised with nitrous oxide gas, a Sims speculum is introduced, and gentle continuous traction is made until partial paralysis of the sphincter vaginal muscle is produced. Sometimes the operation has to be repeated once, but the final result is usually satisfactory.]

A. J. C. S.

#### Emmenagogue.

R Fl. ext. ergot, fl. ext. gossypii, fl. ext. black cohosh, aa  $\frac{5}{j}$ . M. Sig.: Half a teaspoonful every three hours, and using hot fomentations of hops on the bowels.—*Peoria Med. Monthly*.

#### Ulceration of the Os Uteri.

A writer in *American Medical Journal* says:

When we suspect that a woman is suffering from ulceration of the uterus, we propose an examination and forthwith make it, if permitted. We use one of Staufer's speculums, with hollow bulb conductor, stem and check wheel. These speculums are easily introduced, and when in place the vaginal portion of the uterus is well exposed and readily examined.

If we find an ulcerated os, we make the required local application through this same speculum, as follows: R S. H. Kennedy's concentrated aqueous extract of *pinus canadensis* (dark), one teaspoonful; warm water, one tablespoonful. M. Saturate a wad of cotton batting with this solution, and while the speculum is in place, introduce the saturated cotton through it. That the medicated cotton may be placed firmly upon the ulcerated and inflamed os, we put the hollow bulb conductor into the speculum, and with this we push the

cotton entirely through the speculum and against the uterus. We now carefully withdraw the instrument, leaving the medicated cotton in place. This application may be repeated daily, and after a few times the patient can introduce the speculum and apply the medicine without assistance. As improvement takes place the solution can be made weaker.

For making such examination and application, no speculums equal these. And for local treatment in such cases, nothing equals S. H. Kennedy's concentrated aqueous extract of *pinus canadensis*. Richardson & Co., of this city (St. Louis), furnish it in either form required, dark or white.

It is astonishing how rapidly vaginal and uterine inflammation subside under this plan of treatment. Tender parts grow less sensitive, itchings and smartings are relieved, prolapsus disappears in many cases, leucorrhœas are cured, and a general change for the better is enjoyed.—*South. Med. Record*.

[Would that such results could be obtained by others. We have tried the *pinus* and found it to be of some little value, but very far from being omnipotent. It has one great advantage—it is usually harmless.] A. J. C. S.

#### Lymphangiectasis and Lymphorrhagia.

A young woman who presented herself at the clinic of Dr. PAUL ZUR NIEDEN gave the following history: When she was only nine years old she observed a dropping on the floor of a milky fluid, which the doctor said was leucorrhœa. Two days later she noticed numerous little vesicles, about the size of a pin-head, upon the labia majora, and at the same time the external genitals became swollen. The discharge was very profuse, but was lessened by confinement to the bed. Soon

afterwards she had an attack of hæmoptysis, followed by pneumonia, and there was no further trouble with the genitals for several years. When her menses first appeared, however, the discharge began again. A milky fluid was exuded from the labia in such great quantity that at one time, she said, she collected over two pints in four hours. This was again controlled by rest in bed. When first seen by Dr. Nieden there was no spontaneous discharge, but the labia were studded with little vesicles, which exuded a white fluid on pressure. A small piece was excised from one labium, and for several days there was a flow from the wounded surface in considerable amount—five ounces in one night. The fluid was of alkaline reaction and contained only a few lymphoid cells, but very numerous fat-globules. Treatment consisted in the removal of portions of the labia with the galvano-cautery.—*Deutsche Medicinal-Zeitung*.—*Ibid*.

#### Nitrate of Lead in Cancer of the Cervix Uteri.

M. CHERON, in the *Revue des Maladies des Femmes*, says that he has had very good results from the direct application of the nitrate, powdered, to the ulcerated cervix. After touching the ulcerated surface with glycerine he injects about a quart of cold water, containing about a drachm and a half of tr. ferri perchlorid., and then dries the surface with absorbent cotton. Finally the following powder is introduced, by means of a syringe made for injecting powders: R. Plumbi nitrat., pulv.,  $\frac{3}{4}$  ss.; lycopod., pulv.,  $\frac{3}{4}$  j. M.

The powder is retained in place by a tampon of cotton. Through this means suppuration diminishes considerably, as also the bad odor. Even hemorrhage is not so profuse, and in some cases it is entirely suppressed.—*Med. Summary*.

### Constitutional Treatment of Chronic Uterine Disease.

A forcible plea in behalf of constitutional measures in the treatment of chronic womb troubles is entered by Dr. BOISLINIÈRE in the *St. Louis Courier of Medicine*. He concludes his paper by the following practical suggestions:

"The late excessive tendency to specialize has led us to attach, in uterine affections, too great an importance to the lesions and not enough to the general condition. The morbid influence of the constitution on the uterus should be considered first, and the reciprocal influence of the uterus on the organism should be considered as secondary. The uterus does not lead an isolated life in the organism, but it is only a link in that harmonious chain constituted by all the organs, and if the action of that chain be disturbed, there will be suffering in every organ constituting the chain. There will be suffering in the uterus as well as in any other organ, but not more."—*Med. Record*.

### Salicylates in Dysmenorrhœa.

Dr. CHÉRON says that long ago Weit and Simpson recognized the influence of arthritis on dysmenorrhœa, and that this is very well shown by the results of the salicylate treatment. The salicylates most indicated in dysmenorrhœa are the quinine and the sodium salicylates. The sodium salicylate is employed with advantage in the painful crisis of the onset. At the time of appearance of the pains, two tablespoonfuls of the following mixture suffice:  $\mathcal{R}$  Sodium salicylate, 3 ijss.; rum punch,  $\mathfrak{z}$  j. 3 vij.; aquæ destill.,  $\mathfrak{z}$  iij. 3 j. If the pain returns some hours later, the same dose should be employed and pushed till six tablespoonfuls at the maximum, in twenty-

four hours, have been taken. Quinine salicylate is more particularly indicated in arthritic dysmenorrhœa, where lumbo-abdominal neuralgia is clearly defined, and shows itself some days before menstruation. It is best given in powder. When migraine, or muscular, or articular pains appear before menstruation, sodium salicylate given in 15 to 30 grain doses per diem is indicated. If in the same cases there exists a periodical neuralgia, the administration of two-grain doses of quinine salicylate twice daily often has very astonishing effects. —*Gaillard's Weekly*.

### Climatoric Dyspepsia.

Mr. PRANGLEY read a paper on the subject before the Norwich Medico-Chemical Society. It occurs in women between the ages of forty and fifty. The symptoms are those of great nervous depression, with pain on the top of the head, noises in the ears, hot flushes and chills, with curious sensations in the abdomen. The dyspeptic symptoms are those of præcordial distress, with palpitation, costive bowels, coated tongue and foul breath. The treatment consists in the administration of bismuth, bicarbonate of potash, and ammonia, adding valerian if the serious symptoms predominate, followed by quinine, strychnia, and the dilute nitro-hydrochloric acid.—*Med. and Surg. Reporter*.

### Emenagogue.

In a recent editorial concerning smartweed as an emenagogue, in the *Medical News*, it is stated that the drug (whose botanical name is *polygonum hydropiperoides*) is indicated in states of anæmia, functional torpor of the ovaries and uterus due to systematic depression, and is contra-indicated in the condition of plethora. Its power

to stimulate the uterine circulation renders it useful in menorrhagia, and in metrorrhagia due to relaxation of the uterine vessels. Subinvolution of the passive kind with a sluggish circulation, cold hands and feet, and general depression, are also benefited by this remedy. The best form for administration is the fluid extract in five to thirty minim doses, mixed with glycerine and wine, three or four times a day. — *Weekly Med. Review.*

#### Deviation of the Catamenia.

Madame M., 38 years old, began to menstruate painlessly and regularly in her seventeenth year, married at 23, bore a daughter the first year and menstruated seven months after, continuing monthly during twelve years. At the end of this time she was troubled with a cough and abnormal respiration. Several physicians pronounced her tuberculous. After two years the congestion of the lungs had disappeared, to center in the kidneys, causing terrible pain every month. During the menses she passed red urine, large clots of blood and shreds of membrane. In January (a year later) her urine became redder, while the catamenial flow sensibly diminished. In April the uterine flow was scarcely a few drops, while she passed large quantities of very red urine. This lasted three or four days, when the urine became normal in hue and quantity. This was repeated on the following month. In December I was called in and found her on a straw bed (she being unable to endure the heat of feathers) with the clothing elevated, so as to remove all pressure from the sensitive abdomen. She lay upon her back with limbs drawn up, urinating in a vessel placed beneath her. The bowels were bloated and sore, the pulse weak, and the whole condition one of great

depression. The urine deposited large bloody coagula. Ten days later she was on her feet, the abdominal dimensions and sensibility normal, the urine clear, containing neither sugar nor albumen. The cervix uteri was healthy, the surrounding parts were not sensitive, the uterine functions were transferred to the kidneys. I prescribed ergot to be replaced by apiol four days before the menstrual period, continued through it, when ergot was again resumed. Bromide potassium on retiring. January 10th, menses returned under former conditions. Two days before they were again due, I ordered two leeches to the cervix followed by puncturing. There was no pain, and but a few bloody clots from the uterus. Next month less bloating and renal pain, a little more uterine discharge, but copious red urine. The month following about the same. In May abdominal pain, well marked uterine discharge, less blood from the kidneys. June showed further improvement. July, much pain, half the normal quantity by the uterus, and the urine had lost its ruddy tint. August, continued improvement. September, menses nearly normal, urine showing blood only on the first day. October, period and urine normal. November, period abundant, urine clear, and so little pain that she could leave her bed on the third day. Sleeps on feathers; ergot and apiol suspended. December, everything normal, bromide discontinued, tincture of iron prescribed, general condition good. January, '83, in perfect health. A year of treatment was required to recall to the uterus a flux which was borne to the lungs and then to the kidneys. It was a case of pseudo-membranous dysmenorrhœa, or better, a slow exfoliation of the uterine mucous membrane. This pathological condition prevented the catamenial flux from this

organ, and it appeared from the lungs and kidneys. In 1846 Oldham's first observations on the expulsion of uterine mucous membrane was published in the *London Medical Gazette*, attracting great attention. Tilt, several years later, made an interesting communication to the London Medical Society on the same subject. My savant preceptor, Dr. Bernutz, considered Oldham's case as one of an inflammatory state of the uterus, and not an individual affection. M. Courty says this exfoliation appears to be the result of a too great sanguine congestion, a sort of apoplexy of the membrane, with a peculiar disposition to exfoliate. The etiology seems still obscure, but this case is of great importance, showing that the membrane can exfoliate without any determining peri-uterine accidents. The flux is shifted to other organs, a new membrane is gradually formed, becomes vascular and able to support the monthly shock. The treatment seemed to me to have prepared, aided and facilitated the return of the menses to the uterus.—Dr. CARRIGUE in *Journal de Médecine Post.—Obstet. Gazette*.

#### **Treatment of Chlorosis by Blood-Letting.**

The cause of the want of success in the ordinary treatment of chlorosis and anæmia lies, according to Dr. DYES (*Allgem. Med. Central-Zeitung*), in a misapprehension of the nature of these affections. Instead of the blood being thin and bright red in color, it is, he asserts, thick and dark colored. This error has arisen from the appearance of capillary blood as flowing from superficial wounds of the integument or in epistaxis. But this is only a colored fluid which filters through the capillaries, the general mass of the blood being too thick and viscid to pass into the smaller

vessels. This viscosity is owing to the large proportion of white corpuscles, and upon it depend the characteristic symptoms of anæmia. The integument is pale and cold, and by reason of the disturbance of the peripheral circulation, congestions of the internal organs arise. The author regards as erroneous the idea that the white corpuscles are converted into red by the agency of iron, and he condemns this remedy as not only useless but harmful in the conditions under consideration. Anæmia frequently ensues upon recovery from acute affections, and is, according to him, due to the non-elimination of morbid matter from the blood in those diseases. Dr. Dyes advocates phlebotomy in acute inflammatory troubles, especially pneumonia and rheumatism, and laments that this practice has fallen into desuetude. The mistake of the older physicians was not, he holds, in blood-letting, but in the employment, in addition, of purgatives. The two procedures are in no way allied in their effects, but rather opposed to each other. For the benefits accruing from the abstraction of blood are owing to the removal of the excess of white corpuscles, while the production of watery stools only increases the viscosity of the blood by withdrawing its serum. He does not think that simple loss of blood can ever produce anæmia. He never found this condition to exist in invalided soldiers applying for pensions, although many of them had been severely wounded and had lost great quantities of blood. In accordance with these views, therefore, the author discards iron in the treatment of chlorosis and anæmic conditions in general, and resorts to phlebotomy. The local abstraction of blood by leeches or wet cups does not fulfil the indications, as the capillaries only are depleted, and these, as stated above, contain only a

colored fluid with but few white corpuscles. Within an hour after the withdrawal of from three to five ounces of blood from the vein, Dr. Dyes asserts that the hands and feet become warm and the patient is bathed in a healthy perspiration, showing that the disturbance of the capillary circulation has been removed. The appetite soon returns and the insomnia and nervous exaltation subside. The diet should be conformed to the instincts of the patients, who usually crave spicy and well-seasoned food and have a repugnance to more solid nutriment.—*Med. Record.*

**A Successful Closure of a Ruptured Perineum, with Complete Laceration of the Sphincter Ani, without Constipating the Bowels or the Use of the Catheter.**

Dr. W. H. JOHNSTON, of Selma, Ala., writes: "The patient's bowels were thoroughly evacuated the day before operating, and on the morning of the operation were again emptied by an enema of warm water. The rents in the bowel and perineum were closed with three deep silver sutures, and then two superficial sutures of horse-hair were used, which closed every part perfectly; legs were tied together. Operation performed on April 25th. Patient directed to have a cupful of tepid water, with a tablespoonful of listerine in it, and to use this to wash out the vagina every time the bladder should act. On the morning of the 27th an enema of warm water was gently thrown into the bowel, followed by the first action since the operation. On the evening of the fourth day two teaspoonfuls of magnesia were given; bowels acted three times during night; patient was directed to use an enema of a small quantity of warm water whenever she felt that her bowels were going to act. On the morning of May 1st, six days after the oper-

ation, the sutures were all removed and union was perfect. This patient had been unable to exercise any control over the flatus, and whenever her bowels were loose could not retain their contents. My only reason for reporting the case is, that heretofore it has been generally believed necessary to use the catheter for three or four days to empty the bladder, and also it was a rule to constipate the bowel, neither of which procedures seem to be necessary, and the omission of which adds greatly to the comfort of the patient."—*Medical Record.*

**Chronic Intra-pelvic Inflammation.**

Dr. W. H. BYFORD. (*Louisville Medical News*):

The terms parametritis and perimetritis are erroneously supposed by many to include the whole subject of intra-pelvic inflammation. These terms are misleading, because, as now often used, they present to the mind the idea that all cases of inflammation not confined to the uterus must belong to one or another of them. Actual observation teaches the important fact that peri- and para-metritis usually exist together, and are usually complicated with inflammation of the uterus, and not infrequently the ovaries and fallopian tubes are involved. The obvious conditions of chronic parametritis are supuration and chronic pelvic abscess, located more frequently, but not always, in the broad ligament, and the consequence of cellulitis. The chronic pelvic abscess is generally the sequel of acute inflammation, and attains chronicity from imperfect evacuation of pus after acute inflammation has terminated in suppuration. The remedy in such cases is found in surgery, and consists in making a more direct outlet, through the vagina, large enough to at

once completely evacuate the pus and enable the surgeon to cleanse and disinfect the cavity. He cited several cases in illustration of his remarks, and in closing he said that the main object that he had in writing this paper was to caution his associates against the danger of converting a chronic pelvic inflammation into a disastrous acute form. He gave the following summary of suggestions and inferences deducible from them :

1. The sometimes terrible effects of examinations or operations in the pelvis do not often, if ever, take place when there is not a perceptible predisposing inflammation.

2. The inflammation may be so light as to be easily overlooked.

3. It may be an original condition, the sequence of an acute attack long gone by, or it may be the product of some immediately previous examination or operation, the effects of which have not subsided.

4. To avoid the dangers of acute inflammation, we should, in making a first examination for pelvic disease, conduct it in such a way as not to give the patient much pain; and when she complains of much suffering, we should at once desist, even at the sacrifice of completeness of diagnosis.

5. Complaints of much tenderness to the touch, or from the use of instruments, is sufficiently diagnostic of inflammation upon which to base treatment for that condition.

6. If, with such tenderness, a thorough examination or an operation is imperative, it should be done under profound anesthesia. There is no question, in the author's mind, that much less danger of ill effects is incurred in making examinations or performing operations on susceptible subjects under the free use of anesthetics.

7. Examinations or operations should not be repeated until the effects of the first have entirely subsided.

8. As chronic parametritis is a frequent complication of most of the morbid conditions of the uterus, it should be always suspected, and its diagnosis be carefully considered in all cases of metritis.

9. When chronic parametritis is present, it should be the chief, if not the exclusive object of treatment until removed.

10. It is not safe to use the sound, sponge-tent, or intra-uterine stem when there is perimetritic inflammation.

11. It is especially dangerous to replace a displaced uterus, when it is bound down by inflammatory adhesions by any means that will overcome its fixedness by force.

12. The use of pessaries or supports of any kind which find their lodgment in the pelvis is generally followed by disastrous consequences where there is even slight perimetritic inflammation.

13. All local treatment of the uterus must be conducted with the greatest care where this complication is present.

## DISEASES OF CHILDREN.

### Combating Fever in Young Children.

It is often difficult, and in fact not without danger, to administer any efficient febrifuge to young children. In such cases the administration of sulphate of quinine by inunction offers many advantages.

The absorption of the salt is rendered possible by the extremely thin epidermis in very young children. The following unguent will be found efficient:  $\mathcal{R}$  Quiniæ bisulph., gr. xxx.; camphoræ, gr. xv.; unguent. simpl., 3vj. M.

A small quantity may be rubbed in

over the groin or in the axilla.—*Med. & Surg. Reporter.*

#### Resuscitation of Infants.

Dr. GRENET (*Jour. de Méd.*) recommends strongly the use of hot water in bringing to life infants who do not begin to breathe after birth (*Practitioner*). The method (Goyard's) is easily practised, and does not hinder the use of other means of setting up respiration. The child is plunged at once into a vessel of water as hot as it can be borne by the hand (120° F.), and the arms are raised and lowered alternately to simulate the natural movements. In a minute or two the asphyxiated infant begins to grow rosy and to gasp, and presently cries out.—*Weekly Med. Review.*

#### To Prevent Blennorrhœa Neonatorum.

"Immediately after separating the child from its mother it is bathed, and during the bathing the eyelids and their immediate surroundings are carefully cleaned by folds of linen dipped in lukewarm water; afterwards the eyelids are gently separated, and into each eye a drop of a two per cent. solution of nitrate of silver is inserted."

This is Credé's method, and a recent circular from the magistracy of Vienna urges physicians to make its advantages known.—*Med. & Surg. Reporter.*

#### Diarrhœa in Infants.

R. Bismuth subnit., ʒij.; pepsin sacch. grs., xij.; tr. opii. deaderat. ℥x.; syr. simp., ʒss.; mist. cretæ, ʒjss.

M. Sig.: ʒi. every three or four hours.

#### The Diagnosis of Scarlet Fever

Is sometimes so difficult that it is almost impossible to decide that the disease is

present. And yet the importance of distinguishing it early, not only to the patient, but also to surrounding friends, cannot be over-estimated. Dr. J. SPOTTISWOODE CAMERON read a paper on this subject at a meeting of the Leeds and West Riding Medico-chirurgical Society (*British Medical Journal*). He dwelt upon the several symptoms of vomiting, headache, and early delirium, and always insists upon an examination of the throat where these are present. The enlargement of lymphatic glands between the ear and jaw he holds to be of importance in doubtful cases, whilst the absence of the characteristic, or strawberry, tongue does not necessarily exclude scarlet fever. He says that sudden high and persistent temperature in a child, typhus and small-pox being excluded, generally means scarlet fever, and he would strongly suspect the disease in a case with doubtful history where the tongue was moist, with a pale red base and smooth, except that its surface was covered with minute bead-like papillæ. The disease may be present almost without fever, without angina, and without rash, and in such cases the condition of the tongue, state of the skin and urine are important and demand careful consideration. Difficulties of diagnosis in a case first seen may present themselves in any of the stages of the disease, the initial, the eruptive, the defervescence or the convalescent. In the first, measles, diphtheria, small-pox, typhus, pneumonia, quinsy, and simple continued fever may cause difficulty; but the history of previous illnesses, the acute symptoms, the course of the temperature, and the state of the throat are very important, and point to the true nature of the disease, while ulceration of the throat is not common at the beginning of a true scarlatinal angina. A sore throat in a

person who has previously had scarlatina, he holds, may be infective, and quotes a case of that character, but the diagnosis is generally helped by a history of previous exposure. In the eruptive stage, measles, erythema, r  theln, and even urticaria, may require to be eliminated before a diagnosis can be arrived at. In the defervescence stage typhoid fever may be mistaken for scarlatina; and in that of desquamation it may be necessary to separate other febrile symptoms, latent albuminuria, nephritis, and even some skin diseases. He says there is no one sign always present in scarlatina, and in doubtful cases as complete a history of the attack as possible should be obtained, and yet a percentage of cases would still remain in which the only guide to a diagnosis would be a knowledge of the diseased conditions prevalent around.

#### The Temperature of Scarlatina.

DRS. KUVSHINSKY and PASTOR have undertaken a large series of observations on the course of the temperature in scarlet fever, and have concluded therefrom as follows:

1. In a vast majority of the cases the temperature, after a lysis on the sixth to the tenth day, remained normal during the next three to eighteen days (mostly fourteen days), and then again rose to febrile figures (in some cases to 104   F. and above). Within one to five days it again gradually returned to the normal. In some few cases there were observed similar tertiary elevations of temperature, generally on the thirty-fourth to the thirty-sixth day of the disease.
2. Simultaneously with these secondary elevations of temperature, there were almost invariably found some other characteristic morbid phenomena, as swelling of the lymphatic glands (mostly cervical), more or less pronounced renal

affection, reappearance of a diffused angina, inflammation of the endocardium, extreme weakness of pulse, and, lastly, in four cases, reappearance of the scarlatinal rash with subsequent desquamation. Considering the facts stated, Drs. Kuvshinsky and Pastor arrive at the conclusion that re-elevations of temperature in the course of scarlet fever, being far from accidental, are caused by the scarlatinal infection itself. The latter, therefore, in common with some other infectious diseases, shows a disposition to run its course with greater or lesser oscillations in the development of various symptoms of the pathological process.—*Med. Record.*

#### Gall Stones in an Infant.

DR. A. DUNBAR WALKER contributes the following interesting case to the *British Medical Journal*: He saw a male child, three months old, who had been brought up entirely at the breast, and had always been healthy, excepting a slight attack of jaundice, a few days after birth. In the evening it commenced to cry, and continued to do so almost uninterruptedly for six hours, when a sedative mixture afforded a little restless sleep. The next morning a dose of castor oil was given, which soon caused an evacuation. The passage was healthy in appearance, but, upon close inspection, three small ovoid bodies, dark green in color, and as hard as wax, were found. The larger one weighed two grains, the other two were much smaller. These substances seemed to consist of cholesterine; minute particles of the coloring matter of the bile could be detected here and there. This occurrence might account for the crying in many cases, and it would suggest the advisability of looking for these gall stones in the case of fretful children.—*Can. Med. Record.*

## OBSTETRICS.

**New Method of Measuring the Diameters of the Pelvis.**

Dr. I. E. TAYLOR, of N. Y., recommends the following method of measuring the diameters of the pelvis (*Amer. Jour. of Obstet.*): Introduce the hand, and for measuring the transverse diameter turn the thumb towards the right or towards the left, and then estimate the difference between the diameter of the pelvis and the width of the hand, which can be done with the thumb. To measure the antero-posterior diameter turn the hand with the thumb towards the pubis, and make the estimate in a similar manner. Dr. T. believes that when the hand can be introduced, the operator will get a more correct view with regard to the antero-posterior, as well as the transverse diameter, than by any other method which can be employed. If, after introducing the hand into the pelvis, it cannot be rotated freely, it is safe to assume that the pelvis is generally contracted. He believes that the so-called justo-minor pelvis, or what he denominates the naturally faulty pelvis, occurs much more frequently than has been supposed.—*Maryland Med. Journal.*

**The Water-Bed as a Lying-in-Bed.**

Prof. C. BRAUN'S Clinic: You all remember the young primipara who was sent in for artificial premature delivery. She was in the eight lunar month, and was suffering from morbus brightii. The nutrition of the parts was disturbed by the enormous swelling, and the lesser labia had become gangrenous. The vicinity of such a patient endangers the others. So we put her in a room alone, giving her her own nurse and physician,

who were not seen to enter the lying-in wards. We did not consider it advisable to bring about delivery in the mother's condition. In any case, the prognosis for both mother and child was bad. The child had been poorly nourished, must be imperfectly developed and too weak to live, while the mother's chances of recovery in the present state of affairs would be lessened by artificially produced labor. The lymphatics would become engorged with this rotten mass, lymphangitis resulting, then the areolar tissue would be involved, and finally our patient would succumb to septic-peritonitis. Her treatment consisted in frequent irrigation of the vagina with a three per cent. carbolic solution, and thymol dressing to the vulva with appropriate diet. We were expectant three days, on the fourth she gave birth naturally to a 2100 grm. living child. The gangrene spreading we had her placed in a water-bed, in which she has been now five days, without fever and with a good appetite. To put a lying-in woman in a warm bath seemed until recently a strange thing, but theoretically there is nothing against it. The spread of the gangrene is stopped, the putridity is swept away, and she feels perfectly comfortable.—*Obstet. Gazette.*

**Is Craniotomy Justifiable?**

From an analytical study of the subject Dr. MONTGOMERY (*Philadelphia Medical Times*) is inclined to answer the above questions in the negative. He terminates his studies by stating the following proposition: Craniotomy is unjustifiable, as, 1st, it considers only the life of the mother, and destroys that of the child, while it is our duty to endeavor to save both. 2d. In pelves with a conjugate diameter greater than 2½ inches we have other alternatives equally

safe for the mother, which afford the child a chance for life. These alternatives we would suggest in the following order: Where the conjugate measures 3.25 inches or over, the forceps; 2.75 inches or over, version; 2½ inches or over, symphyseotomy, followed if necessary by the forceps. In all subsequent pregnancies, and in the first when distortion is discovered sufficiently early, premature labor should be induced. 3d. In pelves measuring less than 2½ inches, Cæsarean section affords better results for the mother, and should be done whether the child be living or dead.

In a limited number of cases (where the os is dilated) laparo-elytrotomy may be preferred to Cæsarean section. In all cases requiring it, operative interference should be early. The obstetrician should control events, not be controlled by them.—*Med. Record*:

#### Puerperal Septicæmia.

Dr. W. N. BRYANT, of Chester, Vt., in a paper on "Puerperal Septicæmia," (*Boston Med. and Surg. Journal*), sums up the following conclusions: 1. Puerperal septicæmia is a strictly infectious disease, depending upon the absorption of a specific *materies morbi*. 2. The infecting material may come from without or be developed from within the patient. 3. It is amenable to treatment, which should always have for its first object thorough local disinfection. It is a preventable disease, and to this end the utmost care should be used by all attendants upon puerperal women to guard them from infection from without, whilst a systematic course of antiseptic uterine washes should be given night and morning in all lying-in cases for the first ten days following delivery.

#### Treatment of Hæmorrhage in Placenta Prævia.

The following method of arresting bleeding in cases of placenta prævia has been successfully employed by Dr. H. KLOTZ, of the University of Innsbruck. He describes the manipulation in *Wein. Med. Woch.* Inserting two fingers of the right hand into the space behind the cervix uteri he pressed them firmly up between this and the vagina. By means of these fingers he hooked the uterus strongly forward toward the pubis, making firm pressure on the fundus with the left hand, and by digital and manual compression arrested the hæmorrhage. Three-quarters of an hour were necessary for the continuance of pressure in one case before this result was secured. In the two cases in which this method was resorted to the children survived. Dr. Bresky has suggested a similar procedure for arresting the bleeding from an atonic uterus, and it was on this suggestion that Dr. Klotz performed his operation.—*Weekly Med. Review*.

#### Disinfection by Corrosive Sublimate.

The *Med. Times and Gazette* says that Dr. TARNIER, Surgeon to the Paris Maternité, has the greatest confidence in Van Swieten's liquor, employed as an obstetric antiseptic. The midwives and pupils all wash their hands in this liquid, and the whole of the genital region of the patient is washed and injected with a solution of corrosive sublimate at a strength of two-thousandths. Prior to delivery the injection is renewed every three hours, and no accidents from its employment have ever occurred. Dr. Tarnier proposes the disinfection of napkins and mattresses by the same means.

[The bichloride of mercury solution

one-thousandth, is in use in the maternity wards of the Long Island College Hospital, and proves an agreeable and efficient antiseptic.] J.

#### Pregnancy with Occluded Vagina.

The *Med. Times and Gaz.* says that Dr. HYERNAUX, Surgeon of the Brussels Maternity, communicated to the Belgian Royal Academy of Medicine (*Presse Médicale Belge.*), a remarkable case of a woman, aged twenty, who was brought to the Maternity with what seemed commencing pains of labor. On examination an imperforate hymen was found to exist, through which no aperture could for a long time be detected, until at last the rounded extremity of a very fine probe passed into an extremely minute one. The hymen was incised, and found to be five millimetres in thickness. The finger was then introduced into the vagina, which was quite free, and the presentation of the foetal head with a thin os uteri detected. Labor did not come on until a week later, when it terminated naturally in a few hours with a girl weighing 2800 grammes. It seems the young woman had, when she was seventeen years of age, undergone a puncture of the hymen for the discharge of menstrual fluid, and since that time she had, until the period of conception, a slight monthly discharge.—*Med. and Surg. Reporter.*

#### Cæsarian Operation.

Dr. G. LEOPOLD performed recently the Cæsarian operation on a woman æt. 29 (*Arch. f. Gyn.* xix, p. 400). Cause, generally narrowed rachitic pelvis to a high degree, the form of the pelvis being that of a blunted card-heart. The operation which was made according to the modified procedure of Säger (compare

*Arch. f. Gyn.*, xix. H. 2.) was successful for both mother and child. L. dissected off after removal of child and placenta the serosa of the uterus on each side of the longitudinal cut to a distance of one cm., and then resected from the cut a triangular piece of the muscularis uteri, similarly as it is now usually made in the amputatio supra vaginalis uteri fi bromatosi. The suture was performed in such a manner that the silver wire penetrated deeply through the serosa up to the decidua and the dissected pieces of the serosa were laid between the margins of the wound. Besides there were made many superficial silk sutures uniting the serosa. L. is of the opinion that the modified procedure of Säger will limit more and more the operation of Porro, which will find application in only a few well-selected cases.—*Ibid.*

#### The Treatment of Post-Partum Hemorrhage

Was the subject of a paper read by Dr. PERCY BOULTON before the Harveian Society of London (*Lancet*), in which the value of cold, heat, injections of iron and transfusion was considered. He urged the more frequent use of transfusion, as he believed fifty per cent. of those who now die from puerperal hemorrhage would be saved if it was performed. He prefers direct transfusion, from vein to vein, but in the absence of a human blood-giver he thought a solution of salt, of the strength of a drachm to a pint, should be used, the amount injected to be determined by the result. His objections to mediate transfusions are: 1. Loss of time during the blood-letting. 2. Cooling of the blood during whipping, necessitating artificial heating and further loss of time. 3. Chances of embolism from imperfect defibrination. 4. Necessity of a more or less

complicated pumping apparatus, liable to get out of order. 5. Contamination of the blood with bacteria, either during defibrination or from the instrument rarely used getting fouled inside.

#### Induction of Premature Labor for the Relief of Suppression of Urine.

Dr. B. F. BAER relates the treating of a case in which this seemed necessary before the Obstet. Society of Philadelphia (*Med. & Surg. Reporter*). The case occurred in the practice of Drs. Marcy and Mecray, of Cape May, N. J. About the sixth month of pregnancy a general œdema was noticed, and the urine contained considerable albumen and a few casts. The amount of urine passed diminished rapidly while the proportion of albumen increased, and the patient became weak and anæmic. Every means was tried to increase the quantity of urine, but without avail. Among the remedies used were a wide range of diuretics and hydragogue cathartics with Basham's mixture. A sudden suppression of urine occurred at eight months, and but four ounces were passed in forty-eight hours; this became solid when heated; headache and spots before the eyes were now added to the other symptoms, a grumous discharge from the uterus had been noticed for a week, and convulsions seemed threatening. Dr. Baer was called in consultation, and he agreed with them as to the advisability of inducing premature labor. A No. 9 flexible catheter was warmed and softened, and was after great difficulty introduced between the membranes and the anterior wall of the uterus. The cervix-uteri had been lacerated in a previous labor, and was hard and small. Pains of a natural character followed immediately upon the introduction of the catheter. After some hours the pulse became

weak and the patient faint, the os was but slightly opened, and it was considered advisable to administer stimulants, use Barnes' dilators and the Hodge forceps. A dead child was speedily extracted; the latter had been alive in the morning. Four hours after delivery urine was secreted, and in two days the albumen had entirely disappeared. The patient recovered.

#### Labor Complicated by Lipoma of Labium Majus.

In the *Centralbl. für Gyn.*, BRUNTZEL records the case of a primipara in which a tumor, the size of a hen's egg, had existed for four years, which had never given any trouble, save an occasional prolapse after severe efforts. After she had been in labor twenty-four hours, the tumor was drawn out and held to one side by means of a towel, and the child was delivered with the forceps without rupturing either the perineum or the tumor. The latter had seemed to develop on account of the pressure which had been brought to bear upon it during the labor, and afterward seemed harder and less movable. The latter facts caused a change in the diagnosis, which had originally been that of hernia labialis. Three months later the tumor was removed, as it had become a source of great annoyance to the patient.—*Ibid.*

#### Adherent Placenta, Retained for Years, Simulating Cancer.

Dr. GEORGE F. FRENCH, of Minneapolis, Minn., reports the following case in the *Northwestern Lancet*:

Mrs. A., æt. 42, mother of twelve children, has always had profuse menstruation. Four years ago had twins; the placenta was adherent, and had to be detached by force. The attending

physician thinks he must have left a considerable portion of it. Since that time the menorrhagia has increased. Two years ago the patient was delivered of her last child, since which time there has been a more or less constant flow or dribble. For two months it has at times been alarming, and on several cases the attending physician found it necessary to tampon. The patient came under my care the 1st of December. I found her blanched from loss of blood, sallow, and very weak. She could not assume the upright position without fainting. Mingled with the blood which was escaping from the uterine cavity, there was much watery and foul-smelling purulent discharge.

Digitovaginal examination threw no light on the case. No tumor was to be felt; the uterus was neither enlarged nor fixed, but the os so patulous that dilatation was unnecessary. I had hoped to find myself dealing with merely a granular degeneration of the mucous membrane, but the foulness of the discharge and the exhausted state of the patient, made me apprehend grounds for the existence of some cancerous affection as the attending physician had intimated. On the other hand, the complete absence of pain, and the mobility of the uterus, as well as its small size, were grounds for hopefulness. On exploring the uterine cavity, I at once eliminated the possibility of any pedunculated tumor being present, and in order to arrest the hemorrhage, which was still unabated, and to throw greater light on the further diagnosis of the case, I scraped over the surface of the entire uterine cavity with a Sims' curette. The instrument did not meet with the usual resistance common to cases of granular polypoid degeneration (in such cases you can both feel and hear the resistance offered by the underlying muscular surface), but I

brought away a pulpy substance, which, under the microscope, Dr. Hunter discovered to be *placental tissue*. The operation was followed by a severe chill, and the temperature on the next day was  $104^{\circ}$ . This disturbance of the system, however, was very brief, and in forty-eight hours had entirely disappeared. There has not been the slightest return of hemorrhage, and no pain attended or followed the operation. The patient eats and sleeps well, and there is no longer any doubt of a speedy and complete recovery.—*Ibid.*

#### How to Secure the Best Possible Physical Condition after Parturition.

Dr. R. TAUSZKY read a paper on this subject before the New York Academy of Medicine, which, while it contains nothing strikingly new, is worthy of reproduction in parts on account of its practical nature.

First of all, the accoucheur should be careful to cleanse his hands with soap and water, remove all foreign particles from beneath the nails, and then wash the hands in a three per cent. solution of carbolic acid, and afterward oil the hands with carbolized oil of the same strength of carbolic acid mentioned. All instruments and articles used about the woman should be cleansed and disinfected by similar means. Just prior to confinement, or early in the first stage of labor, the bowels should be freely moved by an enema, repeated if necessary. The bladder should be emptied, and if catheterization is necessary, the urine should be drawn with a soft Nélaton catheter, which has been thoroughly cleansed in boiling water, and afterward disinfected. The vulva should be bathed with some antiseptic solution, such as a very weak solution of carbolic acid.

He recommended the use of chloro-

form, especially in primiparæ, not carrying the anæsthetic, however, to the production of full unconsciousness.

The cord should not be tied until the umbilical vessels cease to beat. Dr. Tausky regarded this as a point of practical importance. He also recommended Crede's method of expression of the placenta.

The bowels need not be moved until the third day after labor. It is not necessary, is often dangerous, is even fatal sometimes, to use intrauterine carbolized injections once or twice daily up to the second day, even after natural labor. He believed that such injections should be used only when the lochia are offensive and febrile movement has developed. When the lochia are offensive and there is some fever present he invariably syringes the vagina several times a day with a disinfectant solution, but intra-uterine injections post-partum are necessary only in cases of internal violence, such as sometimes attends the manual separation of the placenta or the use of the forceps. When such injections are used he preferred thymol or simple water to carbolized water, which could be introduced either through a soft catheter or the exceedingly convenient tube invented by Dr. Chamberlain. The injections might be repeated until the fetor of the lochia was either markedly diminished or entirely corrected.

Dr. Tausky protested against the teachings of Dr. Goodell, of Philadelphia, with reference to the parturient woman being permitted to assume the upright position within three days after labor. He believed that the doctrine was a dangerous one, and unwarranted, and maintained that the recumbent posture should be kept, changing occasionally from side to side, for at least eight days after normal delivery, and

especially until the uterus has returned to the pelvic cavity. Dr. Tausky then referred to his experience on the frontier while in the army, and stated that it was not only among the civilized, but also among the savages, that women suffer from diseases peculiar to their sex, and stated that gynecological affections among the squaws were not at all uncommon. He attributed a large percentage of these conditions to early rising after parturition. He then detailed the history of a case which terminated fatally, and, as he believed, chiefly because of the early getting up of the patient.

For pelvic peritonitis, in case it developed, he regarded cold applications as the best that could be employed, but more especially in the early inflammatory stages.—*Ibid.*

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1. Puerperal septicæmia is a strictly infectious disease, depending upon the absorption of a specific *materies morbi*.
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## DISEASES OF WOMEN.

## The Treatment of Spasmodic Dysmenorrhœa.

Dr. JOHN M. KEATING (*Med. and Surg. Reporter*):

I do not know of a more unsatisfactory case to have on hand than that of a young girl, unmarried, just at puberty, with this form of disturbance, or one who has had it for several years, and has had associated with it the distressing embarrassment caused by the slightest allusion to the subject of her ailment, an extreme sensitiveness of the nervous system, hysterical hyperæsthesia, both physical and moral, which is caused by the long suffering and wear and tear of the system. I am sure that most physicians have experienced at some time the great difficulties of such a case. The fond parent, in bringing her daughter to you, expects you to *re-rail* the function which has jumped the track of painlessness and regularity, and yet fondly hoping that that can be readily accomplished by a few doses of some magic drug, without the ordeal of the terrible examination which she has feared you will insist upon, and which has probably prevented the seeking of advice this long time. You know full well, as soon as you see the girl—the acne on her face, the muddy skin, or the chlorotic color, her languid air, or hysterical *nonchalance*—that further examination would not give you additional light. You hear the usual story of malaise, headache, perverted appetite, the history of cramp, of scanty flow at the onset, irregularity in appearance of the period, and total disregard to the thorough emptying of the bowels. The mother will tell you in confidence that the pain at the period is only cured by a little gin or brandy, and your own ex-

perience shows you that the amount of such must necessarily be increased at each time, in order to completely dull the increasing sensitiveness of the nervous system.

Probably an examination would only reveal to you a remarkable accumulation within the lower bowel, the discovery of which could have been arrived at by logical deduction prior to any investigation. When a person has been taking brandy or gin for any length of time for this form of dysmenorrhœa, you may be assured that constipation exists.

The mother tells you that she endeavors to make her daughter prudent, but that she is irritable, unlike herself as of old, and the daughter most naturally dreads your inquisitiveness, and seeks to keep back by monosyllabic answers the true history of herself. The mother states that she "fears she will have spasms." Yes, they do use hot baths, ginger tea, hot vinegar, and finally the excited nervous system yields to free libations of hot gin and water, or a "little of the best brandy," and, absolutely drugged, she will feel no pain or nausea and vomiting will end the cramp.

Do most physicians know that the prescription of morphia and chloral, of "bromidia," of chloroform mixture, which they write at the bedside of the girl writhing in agony from dysmenorrhœa from cold, etc., is renewed and renewed, is copied and carried from this place to that, is sent to friends, is recommended for sleeplessness, for neuralgic headaches, for nervousness, and for all the ills that flesh is heir to? The frightful proportions which the habit of self-dosing at each menstrual period has assumed, the fearlessness and frequency with which the hypodermic syringe is used, or the opium suppositories, shows that the habit is growing upon the

community in the better classes, and that it needs at once most decided disapproval of the medical profession, who unfortunately are, in many cases, the innocent causes of the distressing evil, by thoughtlessly placing the weapon, without caution, in the hands of those who will abuse it.

In the treatment of these cases I have lately adopted a plan that so far has met with success, and I wish some of my medical friends who have the opportunity to do so would make the trial also.

First of all, relieve the bowel of its contents, give a large dose of castor oil, and also see that the lower bowel is well emptied by an enema. By the use of enemata you have a powerful way of treating your case, and at the same time one which will not be abused by your patient. Just before the period is expected the patient should remain in bed with the hips well elevated and lying on her left side; her mother, nurse, or some friend who possesses her confidence should administer an enema of at least a quart of thin strained oatmeal gruel, or, if you prefer it, the ordinary castile soap and water enema, with some castor oil. This will empty the bowel. I do not recommend the fountain syringe, because I would prefer that the patient should have the enema administered to her, and not get into the habit of using it herself. Now, if the period should come on and be extremely painful, the anodyne can be administered by enema; of course a small quantity should be injected, as you wish it retained, and in conjunction with the hot foot bath, warm poultices to the abdomen, and hot drinks of some harmless tea, the relief will soon be obtained.

During the time intervening between the periods I give the following:  $\mathcal{R}$  Pul. ferri exsiccati.; potass. carb.,

$\bar{a}\bar{a}$  gr. j.; ext. belladonnæ, gr.  $\frac{1}{24}$ ; ext. aloës. soc., gr.  $\frac{1}{2}$ ; ext. gent. comp. gr. j. M. Ft. pil. one. One after each meal, and also  $\mathcal{R}$ . Acid. phos. dil., 30 drops, in water before meals, t. d.

I have found the *fluid extract of Gelseminum* in three or four drop doses, t. d., a very valuable drug in averting the attacks of neuralgia. It should be taken for at least *three* or *four* days before the period in very severe cases. The plan of treatment suggested by Dr. Weir-Mitchell is necessary for many very obstinate cases. The generous diet or enforced feeding, rest, massage, *absence from home*, and the controlling influences which are embodied in such a course, are often a necessity for complete cure. In ordinary cases the patient must drink at least a pint of milk twice daily, rise early enough in the morning to get a thorough sponging from head to foot, and take a short walk before breakfast. So far the treatment has been calculated to strengthen the system and regulate the digestive functions. I have incorporated with it the use of electricity. I am surprised to find the great difference of opinion in regard to the value of electricity, amongst my medical friends. Some speak of it as useless, others as troublesome, others say that it is most valuable, but that those who use it should be familiar with all the intricacies of the subject. My experience gives me great confidence in the value of properly applied electricity, and though I have given attention to the subject, and studied the valuable works of Bartholow, Beard, and Rockwell, and the interesting articles of my friend W. R. D. Blackwood, I am convinced that in many cases excellent results will be obtained without, of necessity, putting the physician to the trouble and expense of time necessary to the thorough understanding of the subject of electricity.

and its applications. Exactly how a dose of castor oil acts I do not know, and why an interrupted current of application of *static* electricity should be more useful in amenorrhœa, and why a constant current is more successful in allaying the pain of dysmenorrhœa, I am not prepared positively to say; nevertheless it is the case.

Now, in the subject before us, I have found, with many others, that the *constant* current is very valuable, and it can be used with very little trouble to the physician and no discomfort or embarrassment to the patient. I use a *Flemming* battery of *thirty* cells, which I keep in order so that I am *sure* when I use it I get a current generated.

Strange to say, many cases of want of success owe this to the fact that no current of electricity passes at all. "Get your current," is the first on the list of instructions. About two weeks before the expected period I begin the systematic use, usually three applications a week, lasting about ten minutes. I do not apply the electrodes directly to the uterus *per vaginam*, but find that, by placing an ordinary sponge-covered *electrode*, over the ovarian region, the anode, or positive pole, and the cathode, or negative pole, to the spine, and allow it to remain until it becomes uncomfortably warm to the patient, and then removing it for a moment, I get the best results. I place the cathode first in the dorsal region over the spinal processes and gradually move it down to the sacrum. The anode should rest longer over the left than over the right ovary. I find that *twenty* cells is usually sufficient; the number to use will depend on the patient, using that number that will allow her to keep the electrode on the skin for about one minute without moving it. By this means your patient will not hesitate to come regularly for treat-

ment—so little exposure is necessary, so little trouble on her part is required; and, in fact, the treatment is as satisfactory to the doctor, as it will detain him but a short time. My experience has been that in this way from *six* to *eight* applications will enable a patient to pass comfortably over the following period. In some cases the result is astonishing, and in the meantime, by strengthening the system and inducing regular habits, a permanent cure will be obtained without the use of *anodynes* or *stimulants*. I have noticed that such cases, from school habits, have acquired the stooping posture, and, as I believe that this is a most potent cause of dysmenorrhœa, I have always endeavored to strengthen the muscles of the back by the use of the *interrupted* current to the muscles several times a week, and a system of gentle gymnastic exercises.

In summer, rowing, swimming and lawn tennis will be most valuable when indulged in in moderation.

I do not mean to convey the impression that immediate cure will follow the relief obtained in such cases always. The treatment should be persisted in, perhaps reducing the number of applications before each period, until the patient's health and strength have so improved as to warrant the belief that the pain will not reoccur. The *electricity* takes the place of the *anodynes*.

One of my patients who had suffered agony month after month, and was only relieved by drinking hot gin and water in large quantities, after about *six* applications, menstruated without the least *pain*, and the next period was passed in the same way; but the next one occurred after a fatiguing day of standing, nursing a sick mother, and the pain returned, and she was obliged to have recourse to the battery, which again relieved her. This case was one of remarkable im-

provement, and had withstood all kinds of medicinal treatment, and had been under observation for some years.

#### Dysmenorrhœa Mixture.

Iodide of potassium, 2 drachms; sulphate of iron,  $1\frac{1}{2}$  drachms; distilled water, 2 ounces; tincture of cardamom, 4 drachms; syrup of ginger, 12 drachms. Mix; dose, a teaspoonful three times a day, in a little water. Use two weeks before the period, for two periods.

#### Resorcine in the Treatment of Purulent Vaginitis.

The recent introduction of resorcine into therapeutics has developed some properties which render it especially applicable for external use. CHÉRON has employed it with success in the treatment of vaginitis purulenta, in both the acute and chronic stage. When there is much tenderness, so that a speculum cannot be introduced, a soft catheter or tube is pushed in, and irrigations of from six to ten minutes' duration are practised three times a day of the following:  $\mathcal{R}$  Resorcin., 10; aquæ fortis, 1000. M. As a result, the purulent discharge is rapidly reduced, and the soreness subsides, so that a modification of the treatment may be made. He then applies:  $\mathcal{R}$  Resorcin., 6; amyli glycerit., 69. M. This is to be carried to the bottom of the vagina, with the aid of the speculum, upon a tampon of cotton-wool, which is allowed to remain in place for from twelve hours to fifteen hours. The dressing is repeated every second day. Cure is thus obtained more rapidly than with the ordinary emollients and astringents.—*Le Progrès Médical; Revue Méd. Chir. des Maladies des Femmes.—Méd. Med. Journal.*

[It is a question if the first prescrip-

tion is correct. If it is, then the question arises, which cures the vaginitis—the resorcine or the aquæ fortis?]

A. J. C. S.

#### Cannabis Indica; A Valuable Remedy in Menorrhagia.

"Indian hemp," says Mr. J. BROWN, of Bacup (*British Medical Journal*), "has been vaunted as an anodyne and hypnotic, having the good qualities of opium without its evils. Also in dysmenorrhœa and insomnia it has proved of much benefit. The drug has almost invariably produced some marked physiological effect, even in small doses. Text-books give the dose as ten minims and upward, but five minims is the largest dose that should be given at first. I bought from a good house. The drug is not inert or unreliable. A drug having such marked physiological action ought to have a specific use as a therapeutic agent. Indian hemp has such specific use in menorrhagia—there is no medicine which has given such good results; for this reason it ought to take the first place as a remedy in menorrhagia, then bromide of potassium and other drugs. The *modus operandi* I can not explain, unless it be that it diverts a larger proportion of blood to the brain, and lessens the muscular force of the heart. A few doses are sufficient; the following is the prescription:  $\mathcal{R}$  Tincturæ cannabis indicæ,  $\mathfrak{M}$  xxx.; pulvis tragic. co., 3j.; spiritis chlorof., 3j.; aquæ ad.,  $\mathfrak{z}$  ij. One ounce every three hours."

Dr. Robert Batho, of Castletown, Isle of Man, writes in the same journal: "Considerable experience of its employment in menorrhagia, more especially in India, has convinced me that it is, in that country at all events, one of the most reliable means at our disposal. I feel inclined to go further, and state

that it is *par excellence* the remedy for that condition, which, unfortunately, is very frequent in India. I have ordered it, not once, but repeatedly, in such cases, and always with satisfactory results. The form used has been the tincture, and the dose ten to twenty minims, repeated once or twice in the twenty-four hours. It is so certain in its power of controlling menorrhagia that it is a valuable aid to diagnosis in cases where it is uncertain whether an early abortion may or may not have occurred. Over the hæmorrhage attending the latter condition it appears to exercise but little force. I can recall one case in my practice in India where my patient had lost profusely at each period for years until the tincture was ordered; subsequently, by commencing its use, as a matter of routine, at the commencement of each flow, the amount was reduced to the ordinary limits, with corresponding benefit to the general health. Neither in this, nor in any other instance in which I prescribed the drug, were any disagreeable physiological effects observed."

—*N. Y. Med. Journal.*

#### A Novel Uterine Supporter.

Dr. HOLMAN S. HUMPHREY (*Med. Age*). R Amyli; sacch. alb., āā ʒj.; finely pulv. chloride of sodium, ʒj. M. Triturate thoroughly and put in a bottle; cork tightly.

With the patient placed in a good light, replace the uterus and introduce a long glass speculum of as large a diameter as can easily be used; then with a spatula place one or two drachms of the powder within the speculum, and, using a cotton swab, carry the powder up and pack Douglas cul de sac and all around the neck of the uterus with it, and as the speculum is slowly withdrawn, starch the entire mucous membrane of the

vagina. This will effectually prevent the uterus from descending through the vagina, and gives wonderful support to the vaginal walls, aids in curing leucorrhœa, and last, but not least, is an effectual bar to intercourse, and thus would become a great boon to many suffering women if generally used. Ordinarily the operation should be repeated twice weekly, but if there is profuse leucorrhœa it must be done oftener, and, before applying, the vagina should be well cleansed with syringe and warm soap-suds. I have used this powder a great many times during the past ten years, and find it not only the best uterine supporter in prolapsed conditions, but also a direct tonic to the debilitated structures as well. The combination embodies within itself nearly all the constituents of the tissue, and hence cannot become detrimental by remaining several days within the vagina; the chloride, also, preventing decomposition.

#### Cyst.

WERTH, of Kiel, has reported the case (*Archiv. f. Gynaekol.*) of a woman who had an abdominal tumor which was evidently free from adhesion to the uterus or ovaries. Laparotomy was made, and it was found to be a cyst lying between the layers of the mesentery attached to a knuckle of intestine. It was enucleated easily, and quick recovery without reaction followed. The special point of interest was the character of the cyst, which contained fatty detritus and no epithelium. Altogether he considered it to be a retention cyst formed out of a lacteal and mesenteric gland, and containing chyle. Such cysts are extremely rare, and were first described by Rokitsky. — *Weekly Med. Review.*

**Chlorosis and Fever.**

The temperature of ordinary cases of chlorosis met with in young women is usually believed to be normal. This belief has been contested by Dr. MOLLIÈRE, in a paper contributed to the *Lyon Médical*. His observations were made on eight young women, who presented no other signs of disease beyond the anæmia for which they were under treatment. The temperature was taken every morning and evening in the rectum, over a period varying from two to fifty days, and was found to oscillate between 101.8° and 102.8° F. The amount of urea eliminated per diem was estimated and found to be normal. Mollière suggests that the increased heat may be explained by the hypothesis of a combustion, the products of which are not so easily recognized as urea. Sulphate of quinine was given as an antipyretic, with the effect of reducing the temperature temporarily. This effect, if constant, would, according to Mollière, definitely establish the existence of abnormal body heat in chlorosis.—*Med. Record*.

**On Relations Between Flexions of Uterus and Nervous Affections.**

Dr. H. T. BYFORD, M. D. (*Weekly Med. Review*):

After citing many cases in illustration, Dr. Byford arrives at the following conclusions: 1. There is some direct relations between flexure of the uterus and hysterical symptoms, especially the melancholia. 2. This form of melancholia is not dependent entirely upon occlusion, for in some cases there is neither occlusion nor dysmenorrhœa. I have a case of a primipara with ante flexion without occlusion, whose life was perfectly miserable from despondency, fainting spells, excessive irritability, and foreboding of trouble, who experienced no relief from

tonics, local stimulants or glycerine plugs, but whose nervous symptoms improved from the first introduction of an elm bougie. Ammoniated tincture of valerian has afforded temporary amelioration. 3. That the peculiar dilating, or rather straightening action of the elm, affords much relief. 4. That the beneficial action of the slippery elm bougie is not merely one of stimulation, for in some cases the symptoms are worse until the stimulation has subsided, as in the case of Mrs. D. and many others. I have known cases in which the bougie increased the local discomforts, and yet caused improvement in the nervous condition after its removal. 5. That congestion in any part of the uterus is not a constant factor, for in the first case cited there was no sign of any congestion. 6. That ovarian irritation is not the cause of this kind of hysteria, for the bougies could not relieve ovarian irritation so promptly, since they have rather an irritating than soothing effect upon the pelvic organs. 7. Dragging of the uterus upon the ovaries through the broad ligaments is not the cause either, for the change produced in the position is scarcely appreciable at first, and not comparable with the change constantly being produced by the filling of the bladder. 8. That the iliac pains accompanying ante flexion are not of ovarian origin. 9. That pessaries do not afford as decided relief to the general nervous symptoms as elm bougies. 10. That cutting operations, which endanger the life or health of the patient, are unjustifiable for stenosis, until gradual dilatation of this kind has been tried. One of the most protracted cases I ever treated illustrated this. About three years ago Margaret L., æt. 23, consulted me for dysmenorrhœa, from which she suffered so severely that, although the flow only lasted about three days, she

did not recover from the effects before the four weeks had passed. She was about 5 feet 8 inches high, and weighed about 105 pounds, and was troubled with some melancholia bloating and other hysterical symptoms. Under the slippery elm treatment she improved in health, was relieved of dysmenorrhœa and stopped treatment. She came for treatment again with the same result. Soon after that she went West for nearly a year, and then came back, a year ago, suffering from excruciating menorrhagia, and was almost bedridden all of the time. I used the bougies awhile, relieving the menorrhagia and enabling her soon to go to work as fancy cook. For several months she came very irregularly, averaging about once a month. The dysmenorrhœa returning, she then commenced anew and came twice and sometimes three times a month, up to the present. She now weighs over two hundred pounds, and enjoys perfect health, and has only a slight flexion. Had the cervix been incised in her weakened condition, she would have been in great danger of serious after-effects; she never would have become as strong as she is now; would be unfit for child-bearing, and hence unfit for marriage; and would be in need of the operation for lacerated cervix, to cure her of the mutilation. 11. All uteri that have been incised for stenosis ought to have the lower incision sewed up to cure the mutilation, and the physician who incised the cervix be made to refund the money for the operation and pay the bill for the sewing up.

#### **Naked Eye Anatomy of the Female Genital Organs.**

Before a recent meeting of the Edinburgh Obstetrical Society (*Edinburgh Med. Jour.*), Dr. HART said:

The point I wish to clear up is easily

understood. In the anatomical descriptions of the external genitals, the fourchette and labia minora are stated to be mucous membrane. Anatomists have described them thus, in error, owing to the fact that the external genitals in the cadaver soon get altered, and have a misleading appearance to the naked eye. In the living female, however, it can be readily seen that the fourchette is skin, and that the labia minora are also skin. If I am asked on what I base this statement, I reply that to the naked eye these structures have the appearance of skin; and, further, that the line of separation between skin and mucous membrane can be clearly seen not to include them. Hilton has already noted that at the anal aperture the line of separation between skin and mucous membrane is perfectly distinct, and he terms it the white line. This line is of great importance in determining the fact as to whether piles are external or internal. If the external genitals be looked at carefully, we can trace the line of demarcation between skin and mucous membrane as running along the base of the inner aspect of each labium minus, and passing into the fossa navicularis, separating its skin boundary, the fourchette, from the mucous membrane over the hymen. While Garrigues has drawn attention to the error in the statement that the fourchette is mucous membrane, no one, so far as I am aware, has pointed out the true structure of the labia minora. Turner, however, has described them as muco-cutaneous. The exact relation of the external genitals to one another is of interest. The labia majora have their under surfaces in contact, whatever posture a woman may assume. The labia minora are also in contact, and the fossa navicularis is artificially made when the fourchette is hooked down. This exact apposition of

the external genitals has, of course, a protecting influence on the sensitive organs.

The President thanked Dr. Hart for drawing the attention of the Fellows to this point in anatomy. Though it might seem of small moment, it might be of pathological importance in explaining warts and other growths on the nymphæ. Since Dr. Hart had directed his attention to this point, he had examined several cases, and could confirm Dr. Hart's observation.—*Med. & Surg. Reporter*.

#### DISEASES OF CHILDREN.

##### **Crotalus as a Remedy for Malignant (Hæmorrhagic) Scarlatina.**

Dr. JOHN W. HAYWARD, of Liverpool, England, has come to the conclusion (*Lancet*) that crotalus is a most valuable remedy in those malignant cases of hæmorrhagic scarlatina, to cope with which there has been hitherto no adequate medicinal agent. After waiting to test the drug with great care, he has reported two very virulent cases which were successfully treated by him. In one case the patient was moribund when the crotalus was resorted to, she having grown steadily worse under all previous treatment. The mode of administration is as follows: The cuticle was removed from about the throat with a cantharides blister. To the exposed surface a compress sprinkled with crotalus was applied, and a dose dissolved in a teaspoonful of water was dropped on the tongue every half-hour. The beneficial effects were apparent almost immediately. The retching, which had before been uncontrollable, ceased at once. Gradually the stupid lethargy, broken only by low, weak moaning, changed to a more natural condition of somnolence; the breathing became less labored, irreg-

ular, and sighing. The pulse, which had been 160, and scarcely perceptible, fell within twenty-four hours to 120; and all its characteristics were improved. The rash, which had been brown, rough, scanty, and but faintly visible, came out freely on the body and legs, and was of purple color. The head, previously thrown upward and backward, assumed a more natural position. In the course of twelve hours more the rash brightened, the inflammation and œdema of the tonsils and fauces, which had entirely prevented swallowing, abated so that drinking was accompanied with but little difficulty or pain. The respiration was almost normal. The pulse was 100, and was gaining in force and fullness. A favorable prognosis was given, and the progress was so rapid that the patient was well within nine days of the attack. She was taken sick on the 5th ult., and nearly dead on the 7th; crotalus treatment was begun on the morning of the 7th; it rallied her almost immediately; the recovery was so rapid that a favorable prognosis was given on the 8th, and the patient was well on the 14th.

Dr. Hayward states that this case is not an exceptional one. He has witnessed "over and over again" the marked power exercised by crotalus in these malignant cases of hæmorrhagic scarlatina. He believes that it arrests the blood-poisoning which occasions the disease.—*N. Y. Med. Jour.*

##### **Feeding Syphilitic Infants.**

At l'Hôpital des Enfants Assistés in Paris, where many of the waifs and foundlings of the city are cared for, a unique feature has been introduced by M. PARROT, consisting of a nursing service for syphilitic infants. The nurslings draw their nourishment directly from the teats of the ass, to which they

are presented five times during the day, and three times at night. They thrive under this treatment, and seventy per cent. live, while almost all formerly died when fed from the bottle.—*Boston Med. Journal*.

#### **The Use of the Cold Douche in Ophthalmia Neonatorum,**

By Dr. PAULSEN (*Berlin. Klin. Wochsft.*). This writer recommends the use of a cold injection against the eyelid as a means of getting rid of the pus in this troublesome affection. He employs it at first for two minutes four times an hour, and afterwards every half hour. The effect is to cause opening of the eyes, and thus to permit of complete washing away of all secretion. Thereafter, pencilling with nitrate of silver, or any other means of treatment, may be employed. He advises that the water be not used quite cold at first, and that a little sea salt be added to it.—*Ibid.*—*Med. Med. Journal*.

#### **Disturbance of Locomotion in Infants.**

There are frequently noted in children symptoms indicating a disturbance of the equilibrium, especially during progression and other motions. After citing a number of cases, Dr. BRUCHERON thinks that optic troubles will be found far more frequently to cause these abnormal signs than lesions of the encephalon or of the spinal cord. It is well, therefore, to carefully examine in all such cases the state of vision, and not to ascribe disturbances of motion to central nervous lesion till the eyes have been investigated and tested.—*Med. & Surg. Reporter*.

#### **Some Effects of Nasal Polypi in Children.**

A. JACOBI, M. D., in the *New York Medical Journal*, relates several cases of

obstinate asthma or emphysema in children. The first case was under treatment for some time before the nasal polypus was discovered and removed, when improvement immediately set in. In the second case the nose was examined, a polypus removed; another made its appearance, which was also removed; only ten paroxysms occurred since the removal of the polypi, and these are of a mild type.

"What is the explanation of the relationship existing between the presence of the nasal polypi and the asthmatic attacks, if any such exist?"

It is well known that the presence of any irritation of a mucous membrane will produce effects even at a distance; not a small number of cases of prolapse of the rectum are due to the presence of a polypus situated either upon the sphincter or high up in the rectum.

We often see nasal catarrh coexisting with enlarged nostrils—treatment of the latter curing the former; it is, in fact, the result of reflex action.

The doctor also speaks of the relationship between asthma in the adult and the presence of nasal polypi.

Chorea minor, he says, is due almost exclusively to a local irritation of the mucous membrane, associated with chronic nasal pharyngeal catarrh, the chronic symptoms becoming aggravated during acute exacerbations of the catarrh. An intimate relation exists between the nervous system and the nasal mucous membrane; the trigeminus, with all its branches, is subject to direct or reflex irritation, arising from inflamed condition of the nasal mucous membrane.

The thickened mucous membrane or a polypus in the narrow nasal passage of a child would seriously interfere with respiration, and hence an accumulation of carbonic acid gas in the brain, par-

ticularly about the respiratory centre at the medulla.

The lymphatic system of the nasal mucous membrane and that of the dura mater and the arachnoid membranes are in intimate relations with each other. It will be seen that good reasons have been advanced to show the intimate connection between diseases of the mucous membrane of the nose and cerebral affections.—*Med. and Surg. Reporter.*

#### Infants' Food.

An address was recently delivered by Dr. BIEDERT on the principles governing infants' food (*Deutsche Med. Zeit.*). The leading thought, in the consideration of a nutriment, must always be, the behavior of its various constituents, the absolute quantity, and the relative quantity of each. Milk occupies the first rank in regard to the above conditions, and is best known and adapted for the child. Recognizing mother's milk as the ideal, the substitute most used is cow's milk, which contains relatively too much casein. This makes it necessary to dilute the milk sufficiently until the casein is in proper proportion to enable the digestive organs to tolerate it. But now the contents of fat are diluted to an undesirable degree. In the mother's milk the proportion of fat to albumen is two to one. In the cow's milk it is three-fourths to one. To attain the proper proportion the author has recommended to dilute the cream. However, this cream mixture is not to substitute cow's milk for ordinary food, but the latter should be used as the ordinary cheap substitute whenever sufficiently well borne, first diluted three times its quantity and then less and less. To prevent the milk from spoiling it is sufficient to boil it and then keep it in a cool place. The milch conserves are

next in consideration, and of these the sugared ones are to be preferred, though none have any advantage over the fresh, agreeable tasting and cheap milk. Pancreas milk, in which the casein is partially changed into peptone, is a rational suggestion of Pfeiffer. When it is suspected of becoming sour it should be alkalized. Nutriment that contain no milk have only one indication, and that is fat-diarrhoea, where they are useful, from the fact that they contain little or no fat. Such are solutions of albumen, gelatines (decoctions of calf's-feet, isinglass). Slimy decoctions of oats and barley also, mixed with skimmed milk or buttermilk, and finally the leguminosæ. It has been attempted to change the large proportion of starch in the latter to grape sugar, which makes it more easily digestible, but this succeeds very imperfectly. As filling the above condition of simple and well-known combinations in the least are the "Kindermehle," in which albumen from eggs and from plants, starch and sugar are found, besides the constituents of milk. Like the "Nahrzwiebacke," they can only be of use in the transition period, between the time of fluid and solid food for older infants. The finely-powdered state of the former is an advantage, and the preparations, rich in fat as they are, made in Germany, are preferable.—*Weekly Med. Review.*

#### Constipation in Infants.

In the *Lancet*, Dr. M. C. HATTON recommends the following treatment:

Take one quart of bran meal, tie it up in a pudding-bag so tight as to get a firm, solid mass, put it into a pot of water early in the morning, and let it boil till bedtime; then take it out and let it dry. In the morning peel off from the surface and throw away the thin rind of

dough, and with a nutmeg-grater grate down the dry, hard mass into a powder. Of this from one to three teaspoonfuls may be used by, first, rubbing it into a paste with a little milk, then adding to it about a pint of milk, and finally bring the whole to just the boiling point. It must be given through a nursing-bottle.—*N. Y. Med. Journal.*

#### Infantile Constipation.

For obstinate infantile constipation and its consequent derangements, Dr. T. M. LOWNDS says, in the *Lancet*:

I would suggest the trial of pepsine wine, about five drops given with each meal of milk and water. I have found it best to dilute the milk at first with twice its volume of water, sweeten with sugar of milk and give the pepsin wine in a teaspoonful of the milk and water separately, either just at the commencement or in the middle of the meal. I have always found this abolish curdy stools and constipation in young children.

For the same condition, Dr. JOHN P. HAMILTON recommends milk diluted one-half, and to each ordinary bottle add one or two teaspoonfuls of Dinneford's fluid magnesia. The abdomen should be well rubbed with oil two or three times daily, and night and morning one teaspoonful of cold water or more given if the infant will take it freely. During the first fortnight after the treatment is commenced it would be well to give each second night half a grain of leptandra.

While still another correspondent has found good results from the use of compound liquorice powder.—*Ibid.*

#### Infantile Summer Diarrhœa.

Dr. BLACKADER, in *Canada Med. and Surg. Journal*, thus treats this disease:

With regard to the treatment, our first efforts should be directed to placing the infant under the best hygienic conditions possible. If a selection can be made, the coolest and airiest room in the house should be chosen for the child's cot; if necessary, moving woollen curtains, and such like, that may interfere with the free passage of fresh air through the apartment. The attendant should be impressed with the necessity there is for keeping the child quiet, no unnecessary movement of it being allowed. Should the child be strong enough, it should be taken out twice a day during the cooler hours of the morning and evening, preferably in its carriage to being carried in the arms, and all jolting in driving it should be avoided. When practicable, frequent trips in the cooler and purer air over water are to be desired. The feeding of the infant is of the highest importance. If still nursed, strict injunctions as to the frequency with which nursing is to be allowed should be given. If the child is thirsty between times, as with diarrhœa going on and the excessive heat, it is sure to be, a little well-boiled rice or barley water, or a few mouthfuls of cool filtered water may be given. If the mother's health be in any way at fault, measures should be taken to restore it. If the child be fed by the bottle, even stricter precautions are necessary. A little longer interval should be allowed between the times of feeding, and the greatest watchfulness is necessary to insure absolute sweetness and cleanliness about the feeding bottle itself. Great difficulty is often experienced in these cases to get a food that will agree well. Foods that during winter children thrive on and do well, in the summer season cause acidity and disagree. This is especially true of most of those patent preparations sold for

children's food in the shops. After the trial of a good many, I still rely most, for young infants, on the receipt containing gelatine and arrowroot, given by Meigs & Pepper. And for older infants on a thin pap made from wheaten flour that has been boiled dry in a bag for twelve hours.

At the Infant's Home, in this city, I made careful trial in several cases of milk prepared with the pancreatic extract of Fairchild Bros. & Foster, of New York, but was not altogether satisfied with the result, and some children object to its taste. Wheys prepared either by adding sherry wine or dilute hydrochloric to milk are often of service when the milk is rejected curdled.

As regards medicinal treatment, should the attack be recent, or we have reason to suppose some specially irritating ingesta still remain in the bowel, some gentle laxative should be given, and probably the best is either a small dose of castor oil, in an emulsion of gum-arabic, with an opiate, or a small powder of soda and rhubarb. Otherwise, it seems better to commence at once with a sedative and astringent; and for this purpose nothing seems to answer better than a combination of opium with bismuth. Both must be given in sufficient doses. For a child a year old, half to one drop of tincture of opium with ten or twelve grains of bismuth in an emulsion may be given every three or four hours, or oftener if necessary. If there is much acidity either of the stomach or dejections, a little chalk, as in the official mist. cretæ, may be added. Occasionally we have a great deal of general nervous excitement associated with the earlier stages of an attack. In such cases potassium bromide or sodium bromide may be added, one or two grains to each dose. If we have reason to suppose, from the frothy character of

the dejections, much fermentation is going on, carbolic acid in  $\frac{1}{16}$  to  $\frac{1}{12}$  drop doses may be added to the mixture of bismuth and opium. Where there is mucus and slime, with streaks of blood in the motions, small doses of hydrargyrum perchloride,  $\frac{1}{100}$  to  $\frac{1}{150}$  gr., as recommended by Ringer, has often proved very efficacious in removing these conditions and improving much the general condition. For the troublesome and incessant vomiting, associated sometimes with frequent serous dejections, powders of  $\frac{1}{4}$  gr. hydrarg. with cretæ, or  $\frac{1}{12}$  gr. calomelanos, rubbed up with a little sugar, and given hourly dry on the tongue, will often check the vomiting and alter and improve the character of the dejections. In many cases all our resources will be required to check the inflammation. When necessary, injections containing two or four minims of laudanum, in two drachms of starch water, thrown up directly after the bowels have been moved, and repeated as may be required, give great ease. Poultices in warm weather are, I think, to be avoided; but cloths wrung out of spirits and water, with some laudanum sprinkled on their surface, and applied over the abdomen and then covered with oiled silk, have, I think, proved of much service.

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#### Invisible Cutaneous Perspiration in Healthy and Febrile Children.

Dr. ECKERT, in the *Vratch*, publishes the results of his observations on thirty healthy children from two to fourteen years of age, and on twenty-seven suffering from various febrile diseases. The age of the febrile children varied from eighteen months to thirteen years. The conclusions at which the author has arrived are summed up thus: *a. For healthy children.*—1, invisible loss of water by the skin in children proceeds

with greater energy than in adults; 2, the loss is greatest in children of younger age (under five years), and gradually becomes less as age, height and weight advance; 3, all conditions being equal, any rise of barometric pressure increases loss of water by the cutaneous surface, while any increase of the humidity of the surrounding air inhibits invisible perspiration. *b. For febrile children.*—1, in the febrile state invisible perspiration is augmented; 2, in enteric fever, the greatest loss of water by the skin coincides with the period of maximal mean daily temperature, afterward invisible perspiration decreases with the fall of febrile temperature, and in the period of convalescence it descends considerably below the normal level; 3, similarly, in the course of relapsing fever, there is observed more or less considerable increase in invisible perspiration during the attacks; having reached its maximum at the time of crisis the amount of evaporation rapidly falls, though during the first twenty-four or thirty-six hours after the crisis it remains still rather increased above the standard. During the apyretic intervals and after the termination of the disease cutaneous loss of water falls below the usual level; 4, in scarlatina invisible perspiration is considerably increased.—*Med. Record.*

### OBSTETRICS.

#### Central Separation in Placenta Prævia.

Dr. J. WARD, of Cornelia, Mo., has, during thirty years' practice, met with three cases of central implantation of the placenta, which were attended successfully, as well as an equal number of partial cases. In his experience, he mentions that examination will show the placenta separated for a short distance around the internal os, but that hemor-

rhage occurs only with the pains; hence he advises that the finger be introduced and the placenta peeled off as far as the finger can reach from around the os, after which he tampons until the pains become expulsive. In this view the doctor states that central separation and the tampon gives a good chance for the child, and does not materially impair the chances for the mother. In the second stage the tampon is removed and the following advised: either (*a*) to peel off the remaining placenta on one side, to rupture the membranes, turn the child and deliver by the feet; or (*b*) after having peeled off the placenta on one side, to rupture the membranes and bring the fore edge of the placenta through the os, and hold it against the vagina until the head engages. By this procedure about four inches of the central portion of the placenta is reached, leaving two inches of the circumference to maintain foetal life and circulation. This, he advises, should be done early, by which means full dilatation is permitted, with no more laceration of the curling arteries.

#### The Oxytocic Action of Quinine.

Mr. HARTIGAN, M. K. Q. C. P., of Hong Kong, writes in the *Brit. Med. Jour.*:

"In three different cases I have had on several occasions to discontinue the use of quinine because it brought on 'labor-pains,' though the doses used were small, varying from three to five grains. In one of these, during a previous pregnancy, another medical man used quinine, and discontinued it for a similar reason. All three were in fair general health, suffering only from slight malarious fever, and had never aborted. One case has come under my notice in which abortion took place, without ap-

parent cause, after a ten-grain dose of quinine. The patient was the mother, of several children, had not previously aborted, was in good health, and took the quinine to cure facial neuralgia. I know of another case of abortion under similar circumstances after quinine. This action of the drug is known to the Chinese, who take it (I am told with success) for the purpose of producing abortion, following its use by copious draughts of hot tea. I have myself heard a Chinese 'amah' (*i. e.*, female servant) recommend it. Quinine, certainly in some cases, increases the menstrual flow."—*Med. and Surg. Reporter*.

#### Paget's Disease of the Nipple.

Dr. LOUIS A. DUHRING reports, in the July number of the *American Journal of the Medical Sciences*, two cases of Paget's disease of the nipple, which he holds is not an eczema, but a peculiar disease with a malignant tendency. It must be distinguished from eczema, which it resembles, and from ordinary cancer, which it is altogether unlike in its earlier stages. It seems to occupy a ground having the characters of both diseases. The report is interesting as showing the natural history of the affection. This is peculiar. The course of the process is emphatically chronic. In both instances, moreover, the progress of the disease was insidious as well as slow. Nothing of a malignant nature was suspected until after the lapse of five and ten years, respectively. The itching, which eventually became such a marked symptom, was in both cases insignificant until the affection had existed several years. It may be said not to have manifested itself until after the process had been well established. In this respect the disease differs decidedly from eczema, where itching is one of the first signs noted. The circumscribed,

sharply defined outline of the lesion, and the slightly elevated border, are also symptoms which do not obtain in eczema. The brilliant color of the lesion is striking, and is more marked than in eczema. The absence of the "eczematous surface," characterized by appreciable discharge or by vesicles, pustules, or puncta, coming and going from time to time, and the absence of exacerbations, so usual in eczema, may also be referred to. A point to which attention may also be directed is the infiltration, which is firm or even hard, but is not deep-seated. It is rather superficial. In eczema, on the other hand, it is soft. The pains coming on later in the course of the disease, and the indurated, lumpy or knotted lesions within the gland structure of course point strongly to the malignant or cancerous nature of the disease, the existence of which cannot be doubted.

#### Puerperal Eclampsia.

Dr. BURTON, in the *Medical Press and Circular*, says: 1. That puerperal eclampsia is a motor neurosis associated with loss of consciousness. 2. That it stands in intimate relationship to the convulsions of childhood and to epilepsy. 3. That only one factor in its production is constant, viz., a peculiar condition of the nervous system that may be designated as one of "unstable equilibrium," and that this factor is common also to the convulsions of childhood and to epilepsy. 4. That retention of urinary constituents when present vastly increases the tendency to convulsions in pregnancy, but that outside the conditions of pregnancy and childhood such retention is but rarely the cause of convulsions. 5. That nerve-irritation—shock, emotion, violent pain, uræmic or other morbid condition of blood, etc.—

is capable of setting up sudden vaso-motor spasm of cerebral blood-vessels. 6. That this spasm of blood-vessels, causing sudden anæmia of the brain, is the cause of the convulsions and of the consequent coma. This view of the etiology of puerperal convulsions leads naturally to the treatment, and, in fact, furnishes an explanation of the success that has attended the employment of chloroform, ether, chloral, bromide of potassium, subcutaneous injection of morphia, and blood-letting.—*Ibid.*

#### **Puerperal Infection through Erosion of the Nipples.**

The possibility of septic infection through wounds of the nipples, as well as through wounds of the genital apparatus, has hitherto received but scant notice. Professor KALTENBACH regards this occurrence as probable, arguing from the etiological relation between erosions of the nipple and mastitis, and from the beneficial effects claimed by Hausmann to follow the treatment of the fissures by carbolic acid. Spiegelberg has shown the possibility of mastitis arising from infection through the nipples and openings of the lacteal ducts. Kaltenbach goes further, and regards every case of mastitis as of septic origin. The necessity of the greatest possible cleanliness of the mouth of the child, the hands of the nurse, and the nipple itself is evident.—*Deutsche Med. Zeitung.*—*Ibid.*

#### **Ova.**

To settle the question whether or not it is possible for ova to travel across the peritoneal cavity or that of the uterus, Dr. LEOPOLD, of Leipzig (*Medical Times and Gazette*), has performed some important experiments. In these he made

use of eight rabbits. In each case he opened the abdomen, tied the right Fallopian tube in two places and cut out the piece between the ligatures; the left ovary was carefully removed, then the abdominal wound was closed. After thorough recovery each animal was put to the male. In six cases the result was entirely negative, but in two pregnancy followed. The abdomen of the latter was opened; in one, four placenta were found in the left horn of the uterus, and one in the right. He thinks these experiments settle the question. In these rabbits ova could only reach the uterus by travelling across the peritoneum from the right ovary to the left Fallopian tube; and could only get into the right horn of the uterus by passing down the left horn and up the right. They prove, therefore, that it is possible for ova to migrate, not only across the peritoneum, but across the uterine cavity.—*Weekly Med. Review.*

#### **An Obstetrical Phenomenon.**

In the *Lancet*, Dr. G. YEATES HUNTER reports the case of a Hindoo woman in which placenta prævia, with shoulder presentation, occurred twice in the course of nine months. On each occasion, version was performed, a dead child delivered, and a rapid recovery followed.—*Ibid.*

#### **Puerperal Diabetes.**

A paper by Dr. MATTHEW DUNCAN was read before the Obstetrical Society of London, the author pointing out the distinction between the slight glycosuria of pregnant and suckling women and real diabetes, with its polyuria and large amounts of sugar. Physicians and surgeons were well aware of the dangers introduced into their cases by complication with diabetes. But the subject of

diabetes complicating pregnancy and parturition had attracted almost no attention, and this probably arose from its rarity, which might be accounted for by the disease frequently destroying in women the sexual energies, as it is said to do in man.

The author had collected twenty-two cases in fifteen women, and they demonstrated the great gravity of the complication as respects both mother and child. Of the twenty-two pregnancies (including those ending prematurely), four had a fatal result soon after delivery. In seven of nineteen pregnancies in fourteen women, the child, after reaching a viable age, died during pregnancy. In two the child was born feeble, and died in a few hours, making an unsuccessful issue in nine of nineteen pregnancies. The histories showed that diabetes may intervene on pregnancy; that it may occur only during pregnancy, being absent at other times; that it may cease with the cessation of pregnancy; that it may come on after parturition; that it may not come on in a pregnancy occurring after its cure. They showed that pregnancy may occur in a diabetic woman; that it may not be appreciably affected in its natural progress and termination by the disease; that it is very liable to be interrupted by the death of the foetus.—*London Lancet*.

#### Vomiting of Pregnancy.

The employment of iodine for the relief of the vomiting of pregnancy has been somewhat in vogue for a number of years. And while the success attending its use has been pointed out with more or less enthusiasm, its exact value has never been established. Dr. T. T. GAUNT (*Amer. Jour. Med. Sci.*) has for a number of years been employing the compound tincture of iodine in drop

doses in nearly all forms of emesis, and reports thirteen cases of the most varied character, in all of which vomiting was promptly arrested by the use of the drug.—*Weekly Med. Review*.

#### Vomiting of Pregnancy.

The following drugs have been recommended for the vomiting of pregnancy, which we here arrange alphabetically rather than in the order of their relative importance (*Medical Bulletin*): Arsenic, in the form of Fowler's solution, in drop doses, given before meals, is often of great advantage. Atropia has been highly recommended for the vomiting of pregnancy, in doses of 1-120 of a grain, injected subcutaneously in the epigastric region. It is said to arrest it promptly and permanently after other remedies have failed.

Bismuth, subnitrate, in ten-grain doses, combined with  $\frac{1}{4}$  grain carbolic acid, mixed with a suitable adjuvant, to be taken three or four times a day. Calumba, in tincture, dose five to ten drops; in infusion, dose, teaspoonful. Cerium, oxalate, dose, two to five grains. Usually the best effects are produced after several days' use.—*Sir James Simpson*.

Champagne, tablespoonful doses with ice, every fifteen minutes. Chloral hydrate, with bromide of potassium, ten grains of each at night when the symptom first develops.—*W. C. Burke*.

Copper, sulphate, 1-20 grain three times daily. Hydrocyanic acid, dilute, three-drop doses once in four hours. Iodine, tincture, drop doses every hour or two. Nux vomica, tincture, drop doses every hour or two. Pepsine, five to ten grain doses.

## DISEASES OF WOMEN.

**Manganese as a Stimulant of the Menstrual Organs, and as a Remedy in certain forms of Amenorrhœa and Menorrhagia or Metrorrhagia.**

Dr. FRANKLIN H. MARTIN (*Med. Record*):

From my observations I have been led to consider manganese in any form a direct stimulant to the uterus and its appendages. It may exert this influence by acting as a direct vasomotor nerve-stimulant to the vascular system of the parts, and in consequence of the improved circulation directly increase the tone and nutrition of the organs, or it may exert its whole force through stimulation of the sexual nerve-ganglia, or even possibly the sexual *nerve-centres*, thereby bringing the organs to their normal state of action. At any rate, its action is prompt and direct. In bringing the uterus and appendages to a normal state of menstrual tonicity, when the lack of tone is dependent upon some previous depression of innervation, manganese, in my opinion, certainly has no equal. Even when the cause of the depressed innervation is still acting, this remedy will exert its stimulating power over the menstrual mechanism. In consequence of phthisis, menstruation had not occurred in a young woman, eighteen years of age, for four months. Experimentally the manganese was given in connection with her other treatment. Menstruation occurred within a week. Another young woman, twenty-four years of age, with an aggravating digestive trouble of some years' standing, had become very irregular—flowing profusely for a week or two, then scantily for an equally irregular time, again followed, perhaps without any warning, by a profuse flow or

as likely a complete cessation. This state of affairs had been going on for more than a year. There was no pain with the flow. She was very weak and anæmic from the effects of indigestion and loss of blood. This patient was given two grains of the permanganate of potash, dissolved in one half-glass of hot water, every night on retiring. It was kindly received in this way by the irritable digestive organs. In a very short time there was a decided improvement in the menstrual trouble, and the patient has since menstruated three times normally.

In young girls who are irregular in the early months of menstrual life, where it is simply caused by the natural weakness of the partially developed organs of generation, or where, from an over-worked nervous system, the organs are robbed of their natural nerve-force, this remedy seems to possess the stimulating properties requisite to bring them into healthy action. A remarkable case of this kind was that of a young girl who had menstruated once. Eight months had passed, and the menstrual flow had failed to appear again. The mother of the girl, being alarmed, sought advice. The permanganate was given in two-grain doses twice a day. Within a week the girl menstruated the second time in her life. In two other cases of "missing" in young girls, without any apparent cause, or any other symptoms, the remedy given in the same doses a few days before the next regular period was expected, stimulated the organs to a normal flow. The action of the manganese was so prompt in these cases that I am convinced it was no mere coincidence.

It is well known that from exposure to cold the weakest organs of the body are the ones most liable to suffer. A woman who, when exposed to cold, im-

mediately suffers suppression, cessation, or excess of the menstrual flow, will invariably be found to possess susceptible and weak menstrual organs. In cases of this kind, viz., suppression, cessation, or excess of the menstrual flow, caused by "catching cold," with no other apparent cause, the most gratifying and prompt results are obtained from manganese. The above variety of cases are of so frequent occurrence that in them I have had numerous opportunities to test the new remedy, and I have yet to see it fail, in either amenorrhœa or menorrhagia, when due to the irritation of cold alone. In several cases where the flow was a week or ten days overdue, from "catching cold," the permanganate was given in large doses; and its almost magical effect demonstrated by the flow appearing within twelve hours.

Although I have had greater opportunities for testing the value of manganese in amenorrhœa than in menorrhagia or metrorrhagia, I have received unmistakable evidence of its power in the latter forms of menstrual trouble.

Menorrhagia and amenorrhœa in their outer manifestations are exactly opposite in nature, but they are very often dependent upon the same causes. When the cause is anæmia, or any depressing constitutional disease producing a perversion of the functional activity of the menstrual organs, and this perverted action consists of an irregular or excessive flow, this condition will as readily succumb to the stimulating effect of manganese as when the opposite condition exists. The following cases are of interest: A woman, aged twenty-six, sought advice for excessive and irregular flowing. She had been married two years and had one child, twelve months old. The child was large and strong; the mother physically slight. The

mother nursed the child. For ten months she had stood the strain very well, when she commenced to fail, suddenly grew weak and anæmic, and began to flow excessively. This continued with but a few short irregular remissions until I saw her at the dispensary. She was given two-grain doses of the permanganate of potash four times a day; at the same time all other treatment was withheld. In three days the patient returned saying that the flow had stopped the next day after receiving her medicine. I then discontinued the manganese, prescribed iron and nourishing food, and she continued to improve. By digital examination, nothing abnormal was found in the above case. Another case was that of a large, stout woman, thirty-five years of age, who came to the dispensary suffering from menorrhagia. Her menstrual periods were regular as to time, but the quantity of blood was alarmingly excessive and would last for two weeks. She was married, had three children, the youngest three years of age. This abnormal condition of menstruation had been coming on for a year. The uterus was a little enlarged, and soft to the touch; otherwise, by physical examination, nothing abnormal. Four days before the expected flow she commenced taking the permanganate in two-grain doses three times a day. Menstruation came on at the expected time, and after a normally free flow for four days, passed off naturally. Before the next period the same treatment was repeated, with the same marvellous result.

I have been particular to give here only typical cases. In a number of other cases I have received very gratifying results, and I am myself convinced that in properly selected cases others will be able to obtain like results.

Although manganese, like the allied

metals, nickel, zinc, iron, and silver, has a direct influence on the blood as a tonic in anæmia, chlorosis, etc., it cannot be possible, in my opinion, that its peculiar influence on the catamenia can alone depend upon that virtue. To influence the organs of menstruation by acting as a general tonic, would necessarily be a slow process, and the effect would be very gradual. It undoubtedly, however, as a general tonic, has a predilection for these organs. This was noticed and commented upon by W. H. Broadbent, of London, after experiments performed by him, and recorded in the "Proceedings" of the Clinical Society of London for 1868-69, vol. ii, p. 122: "Manganese," he says, "seemed to have a special influence in promoting the return of the catamenia, and nickel a special property of checking leucorrhœa." But one can readily see by the character of the cases reported by Ringer and Mussell, and myself, that manganese must have a more direct mode of influencing the menstrual organs than by the necessarily slow one of a general tonic. As to what that influence is I am not prepared to advance any more definite opinions than have already been included in this short article. I shall look with great interest in the future for the results of other experimenters in this direction, while personally taking advantage of every opportunity presented to extend my knowledge on the subject.

In prescribing the permanganate of potash (the most convenient preparation in which to administer manganese), it will be well to bear in mind a few points of importance. The preparation has a disagreeable, distressing effect on the stomach when taken undiluted, which may be obviated by administering when the stomach is full—immediately after eating—or dissolved in considerable water. In administering the

permanganate in pill form, it must be remembered that excipients ordinarily used by dispensers will produce with the drug spontaneous combustion. The following basis has been found to act well: "Vaseline two parts, paraffin wax one part; melt, stir till cold, and add kaolin, three parts; mix well," roll out, and dust with kaolin (*Lancet*). Dry gelatin capsules I have found to be the most convenient form in which to administer the remedy.

[Dr. Martin's observations are very valuable, as they tend to show the class of menstrual derangements which are benefitted by manganese. We have used this remedy very frequently of late, and have found that it gives the best results in the menstrual disorders arising from deranged innervation. When amenorrhœa is due to any organic lesion of the uterus or ovaries or to some well defined affection of the general system, manganese has not given us good results, while in the absence of such apparent causes it has acted well.]—A. J. C. S.

#### For Amenorrhœa.

Dr. H. C. WOOD says the following formula, known as *Dewee's Emmenagogue Mixture*, he relies upon almost exclusively in the treatment of simple atonic amenorrhœa. The amount of iron should be as the anemia, of aloes as the state of the bowels, of cantharides as the susceptibility of the urinary organs. R. Tincturæ ferri chlorodi, f ʒ iij; tincturæ cantharidis, f ʒ j; tincturæ aloes, f ʒ j; tincturæ guaiaci ammoniatae, f ʒ iss; syrupi, q. s. ad. f ʒ vj. Sig. Tablespoonful three times a day.—*Cal. Med. Times*.

[At the present time such emmenagogues as the above are rarely used. In amenorrhœa gynecologists usually restore the conditions necessary to normal men-

struation in case that any of them are wanting and if the menses do not then appear, manganese or electricity or both are employed. Such remedies are more agreeable, less likely to do harm, and are as successful.]—A. J. C. S.

#### A Sharp Spoon in Gynecology.

A recent number of the *Archiv für Gynckologie* contains an excellent article by Dr. v. WECKBECKER-STERNEFELD, of Munich, on the use of the sharp spoon in gynecology. (*Medical Times and Gazette*.) This writer's statements are based upon experience, for he gives a table and careful analysis of one hundred cases in which he has used the instrument which he recommends. In this absence of haste, it would be well if his examples were more generally followed; for we have known instruments exhibited and lines of practice laid down by men who have never once used their instruments, or seen a case calling for the practice they write about. The cases in which Dr. v. Weckbecker-Sternefeld advises the use of the sharp spoon (which, we may mention, is that known as Simon's) are these: In abortion, when the ovum or membranes, or part of them, are from any cause retained in utero; in cases of mole, vesicular or fleshy; after labor, in cases of hemorrhage or fetid discharges, caused by retention of bits of placenta or membranes, or polypoid growths at the placental site. The advantages of the sharp spoon as compared with the digital detachment and removal of such offending bodies, he thinks, are these: avoidance of septic infection; the small space required for its use: the completeness with which detached bodies can be removed in the hollow of the spoon; the almost painlessness of the proceeding for the patient; the absence of drag-

ging upon the uterus, and the unirritating character of the proceeding. The instrument is used, of course, in the same way as the curette; it may in fact be regarded as a large curette, so shaped as to be capable not merely of detaching, but of bringing away any mass loosely attached to the uterine wall. The size of spoon which Dr. v. Weckbecker-Sternefeld finds most generally useful is about an inch long by rather more than half an inch across. The angle at which the spoon is set on the handle matters little, but it is convenient to have the direction of the convexity and concavity of the spoon indicated by marks on the handle. Its use does not give pain enough to make anesthesia necessary. Our author, as we have mentioned, gives a careful analysis of one hundred cases in which he has used the sharp spoon. Of these, in nine it was employed for the removal of an ovum in process of expulsion; in thirty-one, for removal of membranes, or portions of them, after the embryo had been discharged; in twenty-seven, for removal of placenta, or portions of it, after premature delivery; in twenty-eight, for the same purpose after delivery at term; in two, for atony of the uterus post-partum; and in the others, for endometritis, deciduoma at the placental site, placental polypus, fleshy and hydatid mole. Of the one hundred cases, five died; three from puerperal septicemia existing before the operation was undertaken, one from enteric fever, one from peritonitis. The last mentioned our author considers the only one in which the fatal result could be connected with the operation, but in this there was also some disease of the rectum, and a previous attempt had been made to effect manually the object for which the spoon was used. In most cases no bad symptoms followed, and

the patients quickly recovered.—*Louisville Med. News.*

#### The Treatment of Pruritus Vulvæ.

Professor N. F. TOLOCHINOFF describes (*Vracheb. Vedom.*), the treatment he successfully adopts in endlessly varying cases of pruritus of the female external genitals. In all cases he recommends washing of the latter two or three times daily with a weak solution of bicarbonate of soda (half a teaspoonful in a basin of water with a tablespoonful of eau de cologne). When irritation, redness and tumefaction are only moderate, powdering with oxide of zinc and starch (1 to 6), or smearing with zinc ointment (3 ij. to 5 j. of spermaceti ointment) are sufficient. When irritation is more considerable, and erosions and exulcerations are present, he applies in addition 2 per cent. carbolic solution, or  $\frac{1}{2}$  per cent. (R. Plumbi acetatis, 3 j; tincture opii, 3 iij; aquæ destill. lb. j). In cases of simple eczema there are indicated Hepra's diachylon ointment, green soap, and other similar remedies. Pubic lice are best killed by the gray mercurial ointment. When pruritus is very severe, but the changes on the external genital parts are only slight, the best results are obtained from ice-dressing, smearing with carbolized oil (1 to 1), hypodermic injections of morphine, and the internal use of bromide of sodium (3 j daily). In cases of diabetic pruritus, the best means is the administration of alkaline mineral waters and salicylate of soda; the latter being useful, too, in pruritus accompanying chronic cystitis. In itching from gonorrhœal urethritis, the author cauterizes the urethral walls with 10 per cent of silver solution (by means of a silver probe). In cases of pruritus from colpitis, the latter is treated by the introduction every third day, through a speculum, into the vagina, of a teaspoon-

ful of silver solution (1 to 30), with subsequent plugging; the tampons (and solution) being left for twenty-four hours. Their removal is followed by an injection of tepid weak solutions of lead or borax. Very useful, too, is the introduction of a powder consisting of crude alum and starch (1 to 5), the powder being retained in the vagina by cotton-wool tampons. In cases of cervicitis and endometritis, itching disappears on dilatation of the cervix and an intra-uterine injection of tincture of iodine or solution of nitrate of silver. A good palliative means, in cases of pruritus from uterine and vaginal catarrh, is plugging of the vagina with hygroscopic cotton-wool (changed twice in a day), as first recommended by Dr. Gaillard Thomas.—*London Med. Record.*

#### Pruritus Vulvæ.

M. VIGIER, in the *Gaz. Hebdomadaire*, gives the following preparations as the best treatment of this distressing affection: 1. *Goulard's Lotion*, which contains 15 centigrammes of sublimate to 100 grammes of milk of bitter almonds. 2. *Vidal's Lotion*: This contains 3 or 4 grammes of chloral hydrate to 100 grammes of rose-water. After each application the part to be dusted with starch-powder. 3. *Guéneau de Mussy's Pomade*: Glycéré of starch, 20 grammes; subnitrate of bismuth and bromide of potassium  $\overline{\text{aa}}$  1 gramme; calomel, 20 centigrammes, and extract of belladonna, 25 centigrammes. To be applied every evening to the pruriginous region.

#### Extirpation of the Uterus.

A remarkable case is reported in the *Deutsche Ztschft. f. Chirurgie*. In 1881 Prof. FREUND extirpated the uterus of a patient suffering from fibroids, she making a good recovery. A year later

she came under Prof. Luecke's care with a cancer of the pylorus, which he determined to remove. After preparing her for the operation he attacked the growth, but resection was found impracticable on account of adhesions to all the neighboring organs. He therefore laid open the pylorus, and uniting the edges of the opening with the edges of the abdominal incision, made this a gastro-enterotomy. The woman recovered from this second formidable operation and was discharged in thirty-seven days, able to digest easily all light, nutritious food.—*Weekly Med. Review*.

#### Uterine Dilators.

Dr. J. R. UHLER read a paper upon this subject before Maryland Medical Society, and suggested various methods of effecting dilatation, among others the following. Three or more smooth steel wires are passed into the uterus, one by one through a single rubber band, and a cork or a piece of wood with notches cut in its circumference is slipped up between the wires as far as desired, which is to act as a fulcrum. India rubber bands are now slipped over the exposed end of the wires, which, by their elastic tension separate the other ends, thus exercising dilatation of the cervical canal. The wires may vary in size and may be straight or bent and may be provided with a shoulder to prevent their entering too far into the uterus. A number of elastic bands may be used if necessary to overcome a very thick and firm cervix. Dr. Uhler claimed for this contrivance cheapness, simplicity, pressure gradually applied and readiness of construction. Ordinary knitting needles may be used, and in the absence of the rubber bands a piece of hose, old suspender or garter will suffice. The ends of the wire should be well

rounded, and if the os be somewhat patulous, a piece of small rubber tubing may be slipped over the end of each wire. The instrument is easy of introduction and may be used in the smallest strictures.—*Md. Med. Journal*.

#### Absence of Vagina, Uterus, Ovaries—Enormous Distension of Urethra, without Incontinence.

From the *Med. Record*, we note that Dr. JAMES F. FERGUSON, visiting surgeon to the Charity Hospital, New York, relates the history of a prostitute admitted October 25, 1881. Father was consumptive; mother died of pulmonary hemorrhage. The patient was the tenth child. She denied all previous venereal trouble. Although eighteen had never menstruated, nor did she give any history of vicarious phenomena. She noticed a pimple on the posterior commissure at the time of admission, followed by a discharge, with scalding on micturition. There were three small chancroids in the posterior commissure. The chancroids were touched with carbolic acid and dressed with iodoform. On the 29th of November, the parts having healed, a further examination was made, when no vagina was found; the meatus urinarius and urethra were very much enlarged. The sores above mentioned prevented an earlier examination. The labia are well developed. An examination was made by Dr. Ferguson, with Dr. Walter R. Gillette and Dr. E. S. Peck. They failed to find a uterus or ovaries. Investigation was made by the finger in the urethra; also bimanual touch through the rectum and by sounds. The outer portion of the urethra was greatly dilated; she did not have incontinence of urine. She was well developed, breasts well formed, also the nipples. The mons of normal size. The labia, nymphæ and clitoris

presented the usual appearance. In this very remarkable case the unusual feature is exhibited of a urethra largely distended, with no incontinence of urine.

—*Med. and Surg. Reporter.*

#### Antiseptic Precautions taken in Ovariectomy in Billroth's Clinic.

In the performing of ovariectomy, or any abdominal section, Prof. BILLROTH takes the utmost care that in every detail of the operation the strictest antiseptic means are employed. All abdominal operations are performed in a special room. This room is very frequently cleansed in the most thorough manner, and during the operation the temperature is kept at 20°C. The day previous to operating, the patient gets a warm bath, and on the morning of the operation the bowels are emptied by injections. The abdomen is thoroughly washed twenty-four hours previous to the operation, and over night it is covered with compresses soaked in a two per cent. carbolic acid solution. Immediately before operating, the bladder is emptied by an assistant, who does not take any part in the operation afterwards. The vagina is washed out with a one per cent. of carbolic acid solution, and afterwards filled with strips of iodoform gauze, the object of this being that, should, during the operation, any communication be made between the vagina and abdominal cavity, the danger of septicity will be much diminished. For an hour previous to commencing the operation, a five per cent. spray is kept going in the room. The spray is, however, not used after the abdominal cavity is opened.

The sponges used in this, and, in fact, in all operations, are cleaned, bleached, and made antiseptic in the following manner:

1. They are cleaned from sand by

being pressed between the folds of a towel; they are then repeatedly washed in lukewarm water which has been previously boiled. The water should not be hot, as it causes a shrinking.

2. In order to bleach them, they are put into a solution of the permanganate of potash (1-1,000) for 24 hours, and afterwards well washed in lukewarm water. They are then put into a solution of subsulphite of sodium (1-100), to which has been added a fifth of the quantity of a solution of hydro-chloric acid (8-100). In this mixture they are kept for a few minutes only. After their removal they are again washed in water, and are finally left for three days in cold water, which is frequently changed.

3. To render the sponges antiseptic, they are first placed in lukewarm water, where they are left from three to five days. The water should be changed daily. They are afterwards placed in a five per cent. solution of carbolic acid, where they are left until required. The solution should be changed every 14 days. Sponges are never used unless they have, at least, lain 14 days in this solution. Fresh or dry sponges are never used.

Care should be taken that a sponge is not left exposed to the air for any length of time during an operation. After operations, where the wound is fresh, the sponges, before being put back in the five per cent. carbolic acid solution, are kept in water for a couple of days to remove the blood coagula, and, for the removal of fat, in a soda solution for a few hours. Sponges that have been used in putrid wounds are burnt. In ovariectomy, the sponges are removed from the five per cent. solution, well pressed, and placed in a one per cent. warm solution of carbolic acid.

The operator and his assistants wear,

during the operation, freshly-washed linen coats, which, just previous to commencing work, have been exposed for some minutes to the carbolic acid spray. Bleeding vessels are tied with antiseptic silk. The pedicle is also tied with antiseptic silk. The external dressings consist of a strip of iodoform gauze, which is placed in direct contact with the abdominal wound, several layers of carbolic acid gauze, and antiseptic cotton.—*Can. Med. and Surg. Journal.*

#### The Indications for Hysterectomy.

Dr. WILLIAM M. POLK (*N. Y. Med. Journal*): It is a well-established rule in surgery that so desperate an operation as Freund's is now acknowledged to be is not to be performed unless there exists reasonable hope of a permanent cure. In extirpation of the uterus a permanent cure becomes impossible the moment the pelvic glands become infected, they being so placed as to forbid any attempt at their removal. The immense number of lymphatics running from the uterus and their close connection with the pelvic glands make it almost a matter of certainty that in every case of cancer the latter speedily become infected. There is no question but that this implication may exist sometimes before the glands become enough enlarged to be recognized, so that in any given case it would be impossible for one to say with certainty that the disease was confined to the uterus, merely because no indurations or enlargements were to be felt in the surrounding tissues.

In uterine cancer, the disease commonly begins at the cervix near the external os, and extends upward as well as outward. If, from the local and general conditions present, we had good reason to believe that the disease was confined to the cervix, and such was actually the case, amputation of the entire

cervix, an operation comparatively safe and easy, is all that would be required. Should the disease have extended into the body, it would surely have reached the lymphatic glands, for the tonic required for the former is ample for the latter. Such cases would, therefore, be beyond any *curative* treatment, Freund's or other, palliation being all that is possible.

Touching the few cases of cancer which begin in the uterine body, it is simply a question as to the time of recognition. In the early stages they are regarded as instances of hypertrophy of the mucous membrane with what are called granulation formations; and as such are treated with the curette. Should such a case be recognized as cancer, before there was any decided enlargement of the uterine body, perhaps it would be fair to look upon it as one fit for Freund's operation, for prior to such enlargement the chances of glandular implication are remote. But, cases of primary cancer of the uterine body being comparatively rare, and their early recognition by no means easy, the opportunity for the operation in question, even here, is by no means common.

In sarcoma of the uterus the operation holds a strong position. In this disease glandular infection is far less rapid, the disease remaining localized longer than pure cancer, patients dying as often from septicæmia and pyæmia, resulting from the repeated efforts with the curette, as from the unmolested disease.

A large proportion of these cases can be recognized before glandular infection has occurred, even before there is any decided enlargement of the uterus—consequently, when everything is favorable, not only for its operation, but for its early justification and cure. The disease, however, is very rare.

I may sum up by saying that in cancer of the cervix, the common form of uterine carcinoma, Freund's operation is contraindicated; for the disease, if local, can be eradicated by the amputation, if necessary, of the entire cervix, whereas, if glandular infection has occurred, a cure is impossible, palliative measures being then all that are justifiable. From this category I would exclude Freund's procedure, for it is, in my opinion, less useful and far more dangerous than a combination of the many now in vogue. In primary cancer of the body of the uterus it is justifiable, provided the diagnosis be made before glandular infection has occurred; but this is a difficult, and, in some instances, an impossible question to determine, and that too in a rare disease.

In sarcoma of the uterus it is fully justified, and the conditions for it can be determined with reasonable certainty. Yet the disease is far from common; consequently, the field open to the operation is very narrow.

#### DISEASES OF CHILDREN.

##### Dr. Tebault's New Process of Vaccination.

From *Gaillard's Med. Jour.* we note that Dr. TEBAULT, of Louisiana, said that for the past twenty years he had been performing these operations of modified inoculation, and in no case had it ever failed in his hands. He had operated with success upon smallpox cases who had recovered from the disease, within six months of such recovery, and had in such cases repeatedly tried the best vaccine, but without result. His reasons for recommending the practice of his modified inoculation are these. 1. It never fails, and it acts more promptly than vaccination. 2. All his experience assures him that per-

sons so operated on do not communicate smallpox by contact, acting in this respect precisely as vaccination. 3. Physicians can always procure it from a healthy source, and can always have it on the appearance of the first case in our midst. 4. The presence of this most loathsome and dreaded of diseases, by this operation, can be converted from a cause of infection into a means of positive protection to all exposed. 5. Inoculation, thus modified, procures effects as uniform as does vaccination, with the advantage that it is always successful; whereas vaccination has frequently to be repeated several times before it succeeds, thus losing valuable time, when every moment may be important. 6. Modified inoculation will succeed, it matters not how often the person operated on has been successfully vaccinated. The operation consists in taking the first vesicle that presents itself, and admixing the lymph from this vesicle in cow's milk in proportion of one drop of lymph to three or five of milk, according to the age of the subject to be operated on.—*Med. and Surg. Reporter.*

##### A Rare Form of Imperforate Anus.

Dr. RAMONET relates the case of a child, three days old, who was brought to him on account of imperforate anus. There were up to that time no symptoms of strangulation of the bowels. The perineum presented a perfectly plane surface without elevation or depression to indicate the point at which the rectum terminated. But at the upper and posterior part of the scrotum, at the median raphé, there was a small orifice through which a little meconium escaped. A sound introduced into this orifice could be passed backward just beneath the integument to the point at which the anus ought to be. The ope-

ration showed that there was no deviation of the rectum; it was well formed and ended in the normal situation. The anus, instead of opening directly, formed an elbow beneath the skin and terminated with a fistulous opening at the root of the scrotum.—*Revue Médicale*.

#### A Specific for Singultus.

This very common affection, of infants and children especially, has a specific remedy, at least one which I have never known to fail. Moisten granulated sugar with good cider vinegar; give to an infant from a few grains to a teaspoonful. The effect is almost instantaneous, and the dose seldom needs to be repeated. I have used it for all ages, from infants a few months old, to those on the down-hill side of life.—HENRY TUCKER, M.D.—*South. Med. Record*.

#### Management of "Summer Complaints" in Children.

Dr. C. BARLOW thus concludes an article in *Med. Age* on treatment: In some cases small doses of mercury with chalk were given in the first stage, combined with opium and bismuth, which latter remedies formed the main treatment in many cases. Simple cases did well on laudanum, catechu and chalk mixture. I also used the pulv. creta comp. c. opio with excellent results. In protracted cases I used aromatic spirits of ammonia with bismuth, simple syrup and water. I also gave lactopeptine with good results. Quinine was given to nearly all of these patients. To those under two years of age it was given by inunction in the axilla and sometimes over the abdomen. I usually ordered the abdomen bathed with turpentine three times a day. In some cases I used warm fomentations over the bowels with very good results,

but the most obstinate cases progressed more rapidly when cold applications were used; and in many cases I believe them to be of great service. Diet and proper hygienic management were always attended to.

#### Water for Infants.

With the exception of tuberculosis, no disease is so fatal in infancy as the intestinal catarrh of infancy, occurring especially during the hot summer months, and caused, in the great majority of cases, by improper diet. There are many upon whom the idea does not seem to have impressed itself that an infant can be thirsty without, at the same time, being hungry. When milk, the chief food of infants, is given in excess, acid fermentation results, causing vomiting, diarrhoea, with passage of green or greenish-yellow stools, elevated temperature, and the subsequent train of symptoms which are too familiar to need repetition. The same thing would occur in an adult if drenched with milk. The infant needs, not food, but drink. The recommendations of some writers, that barley-water or gum-water be given to the little patients in these cases, is sufficient explanation of their want of success in treating this affection. Pure water is perfectly innocuous to infants, and it is difficult to conceive how the seeming prejudice against it ever arose. Any one who has ever noticed the avidity with which a fretful, sick infant drinks water, and marks the early abatement of febrile and other symptoms, will be convinced that water, as a beverage, a quencher of thirst, as a physiological necessity, in fact, should not be denied to the helpless members of society. We have often seen an infant which had been dosed *ad nauseam* for gastrointestinal irritability, assume, almost at once, a more cheerful appearance and

rapidly grow better when treated to the much-needed draught of water. If any one prescription is valuable enough to be used as routine practice, it is, "Give the babies water."—*Medical Record*.

#### French Treatment of Croup.

DR. JULES SIMON treats croup as follows: As soon as the malady is diagnosed he touches the throat with lemon-juice, or a solution of muriate of iron, every two hours. Every three hours he washes the part affected with a solution of borax (two drachms to the ten ounces). At the same time the atmosphere of the room is charged with atomized phenic solution, a stimulant nourishment is given, and three to five drops of tincture of iron administered every three hours. When dyspnoea becomes apparent an emetic is to be given, but if the symptoms are not relieved tracheotomy must be performed without delay. The results of the operation are not, however, very satisfactory, as when the child is under two years a fatal termination is the rule, whereas above that age one out of five recovers. The after-treatment consists in placing a piece of tarlatan over the canula, warming the room, and administering beef-tea and tincture of iron. The removing and cleaning of the canula should be done by an experienced person; it might be definitely removed after the eighth or tenth day. M. Simon considers that chlorate of potash is of little use in croup.—*Ibid*.

#### Enterocolitis of Children.

DR. E. CARMICHAEL ROTHROCK (*Med. Summary*).

This disease is generally designated as cholera infantum or dysentery. The symptoms pertaining to this complaint are similar to a great

extent to those of the above diseases; but yet different from them in some minor points. It is an intestinal catarrh, summer complaint, inflammation of the mucous membrane of the small intestines, and frequently of the colon and rectum, and is caused by teething, improper diet, extreme summer heat. Malaria is a fruitful cause, as also the mother's milk in certain conditions, or when the woman is not healthy. It is characterized by a persistent diarrhoea. The discharges vary considerably in quantity, frequency and color, being large, thick and feculent at first, then becoming more liquid, of an ash or whitish color, again yellow, changing to a green color. Again, the discharges are small, slimy, mucous, and at times mixed with blood, or stringy, bloody stools, like water that had beef washed in it. The stools are frequently fetid and extremely offensive. Vomiting is one of the symptoms, caused by reflex action, the stomach sympathizing in the abnormal condition, but not persistent as in cholera infantum,—vomiting frequently being excited by water, food, or any article being taken into the stomach. There is more or less fever of an intermittent type, pulse running up quite high, and in a few hours down to near normal, to be followed by the same condition. The extremities generally cold when the fever remits, showing a deficient nerve and capillary power. The fever is generally highest in the evening, and remits by ten or twelve at night. In those cases where malaria is the main factor, or one of the causes, which is the case in nine out of ten patients in the South, the type of fever will assume a continued form, with slight exacerbations. Thirst is also one of the most troublesome symptoms. There is pain over the abdomen, tenesmus and tympanitis. The strain is frequently distressing, pro-

ducing prolapse of the rectum from one to one and a half inches, as I have seen. The acute stage soon runs its course, terminating in recovery, death, or in the chronic form, which may last for weeks, terminating in recovery, or in exhaustion and death. This disease more frequently attacks children from six months to two years of age.

*Treatment*.—The most important and vital consideration is the directing of the child, for without care in this respect no medical treatment will be effective. If the child is nursing and its mother is healthy, then the mother's milk is the proper food. If the child is weaned, cow's milk, one part, water one or two parts, should be used. No solid food should be allowed. The goat's milk is better than cow's milk, as I have demonstrated for years. If goat's milk is used it should have no water mixed with it. The animal should be healthy, and its milk used as fresh as possible. If the milk is vomited, barley, rice, cracked wheat, or tapioca water should be used. Mutton water is fine in this complaint and agrees better than any other meat extract. Beef or chicken water could be used in small quantities. If the child has teeth, light flour bread or soda crackers, rendered soft by boiled milk, could be used. The juice of stewed blackberries, raspberries or strawberries is very good and of advantage, will allay thirst and have an alterative effect on the inflamed bowels. The clothing should suit the changes of the weather. In most cases flannel should be worn, maintaining as much as possible an equitable temperature of the skin. Aro. syr. rhei in proper doses is a good remedy. *R.* Pre. chalk, pul. acacia, aa 3 j; glycerine, 3 ss; port wine, 3 iss; aqua, 3 ij. *M.* Dose.—Ten to sixty gtts. every two hours as to age; paregoric, cranesbill,

tannin, or catechu to be added if indicated. If the tongue assumes a yellow coat give podophyllin, 1-16 to 1-8 gr.; leptandrin, 1/4 to 1/2 gr. The tongue is generally slightly coated, and of a strawberry type. If it is very red a few drops of aro. sul. acid per day, or lemon juice is indicated. If the discharges are offensive give baptisia tinct., two gtts. every three hours, or creasote one-half gtt. every 4 hours, or a few drops of listerine per day. If the discharges are green, saturate. tinct. podophyllin, 4 to 10 gtts.; water, 3 iv. Teaspoonful every two hours. *R.* Sub. nit. bismuth, grs. i to vj; tannin, grs. i to ij; pepsin, grs. ss to j. Alternate every hour with above. If there is much straining, use enema of starch, medicated with sul. zinc or tannin; tinct. opii one drop. Teaspoonful at a time, every three hours as needed. If the bloody discharges continue, then give three times a day: *R.* Nit. silver, gr. j; Fowler's solution, gtts. ij; aconite, gtts. ij; aqua, 3 vj. One-half to one teaspoonful three, times daily. If there is much vascular excitement give gelsemium and quinine. Have had good effects from salicin (ext. willow), 1 to 2 grs. every three hours. If there is much debility, emaciation, then give: *R.* Fl. ext. serpentaria, wild cherry, aa 3 j; ext. malt, 3 j; port wine, 3 j. One-half to teaspoonful every three hours.

## OBSTETRICS.

### The Hypodermic Injection of Blood.

In the *Archivio per le Scienze Mediche*, vol. vii., Dr. CARLO BAREGGI presents a *résumé* of a prize essay written by him and published in Milan in 1882, upon the subject of the hypodermic injection of blood. His conclusions were derived from physiological experiments

upon animals and clinical investigations in disease. Various methods were practised, and blood from different sources was used, but the best results were obtained with defibrinated blood taken from the same species as that of the receiver. In the human subject a donor was selected who was perfectly healthy and free from any hereditary diathesis and, if possible, younger and of the same sex as the receiver. If more than six ounces of blood was desired it was obtained by venesection, but when a smaller amount than three ounces was wanted it was taken by means of a wet cup in the palm of the hand. In the earliest experiments he employed an ordinary Pravaz syringe; but later, in order to avoid the great number of punctures and the increased danger therefrom, he made use of an instrument similar to that employed by anatomists for injecting the minute blood-vessels and lymphatics.

The author sums up the results obtained, as follows: 1. Hypodermic injections of blood in amounts of one gram are absolutely innocuous. When greater quantities are used, the injections are relatively harmless according to the regions of the body in which they are practised and the method employed. The parts of the body which best tolerate the injections are indicated in the original memoir, where also the best method of operating is described in detail. 2. In man, hypodermic injections of blood are always followed by a slight febrile movement, varying in duration from a few hours to, at the most, two days. 3. The red globules of homogeneous blood, defibrinated or not, injected into the subcutaneous connective tissue, are absorbed, in part at least, unaltered, and pass into the general circulation. Their course is from the lymphatic spaces in the connective tis-

sue into the lymphatic vessels leading from the part, through the glands met with on the way (unless these are in an advanced stage of fibro-adipose degeneration or in some other way profoundly altered), and thence into the receptaculum chyli and thoracic duct. They are found in the principal lymphatic trunks of the part twenty minutes after the injection was practised; and even after three days, numbers of them in a good state of preservation were encountered in the thoracic duct. The greatest number was met with twelve hours after the injection, but even after fifteen days, quantities of red globules, but little changed, were seen passing from the cellular tissue into the circulation. Absorption of the mass of injected blood proceeded rather slowly in individuals in whom the circulation was sluggish, especially in those in whom there was considerable subcutaneous adipose tissue, but more rapidly under normal conditions of the heart's action and in persons in good general condition. The red globules were unchanged after remaining many days in the cellular tissue, except in cases in which there was considerable febrile reaction. 4. Hypodermic injections of blood are capable not only of arresting the progressive deterioration in the quality of the circulating fluid, caused by insufficient nourishment or repeated losses, but also of increasing, in spite of such persistent influences, the corpuscular richness of the blood. 5. This increase in the relative proportion of red globules is equal, or very little inferior, to that obtained by the administration of ferruginous tonics in cases in which these remedies are tolerated. The improvement shows itself very soon after the first injection, and persists long after the treatment has been discontinued. Together with increased richness of blood comes a

marked improvement in the general nutrition and nervo-muscular force. 6. To obtain such effects, it is necessary to repeat the injections several times at intervals of five to fifteen days, and to inject each time a considerable quantity of blood. In one case Dr. Bareggi made four injections of 100, 100, 120, and 130 grams (3 to 4 ounces) respectively in twenty-nine days. The relative proportion of hæmoglobine was more than doubled. In a second case four injections of 200, 300, 150, and 240 grams ( $4\frac{1}{2}$  to  $9\frac{1}{2}$  ounces) respectively were practised in the course of twenty-two days, and the proportion of hæmoglobine was nearly doubled. 7. If these results are compared with those obtained by intraperitoneal transfusion, it will be seen that they not only equal but surpass them, and that without any danger to the patient, and by a method at once easy and inexpensive. "In the hypodermic injection of blood, therefore, we have a new and most valuable therapeutic resource. It is especially adapted to the treatment of those cases of slowly progressive anæmia in which the digestive canal is extremely irritable and unfit for the reception, retention, digestion and transmission to the blood of nutritive materials and medicaments. — *Med. Record.*

#### Acute Anasarca without Albuminuria in Pregnancy.

The following case is related by Dr. M. H. RENDUE in *La France Médicale*: A woman, twenty-two years of age, pregnant for the second time, suffered greatly from fatigue and anxiety while nursing her first child, who was sick with meningitis. She took cold, as she supposed, one night toward the end of the child's sickness, and had repeated chills with lumbar pains and general weakness. Soon a persistent headache supervened,

accompanied by nausea and anorexia, but without vomiting. About five days later the patient noticed that her legs were swollen, and the anasarca in a short time became general, but was especially marked in the eyelids and breasts. The pulse was 110; temperature, 103.5°. The urine was scanty, less than thirty ounces being passed in twenty-four hours, was red in color, and deposited urates in abundance. It contained, however, no trace of albumen, although daily examinations were made for a month. The other organs seemed healthy, the heart was normal, and there was no history of recent scarlatina. The patient was placed on milk diet and diuretic remedies, but continued to grow worse until it was feared that œdema of the brain would ensue and give rise to eclampsia, or that the patient would die from pulmonary œdema. It was then decided to bleed the woman, and accordingly between nine and ten ounces of blood were taken. At the same time numerous punctures with a fine needle were made in the swollen vulva and legs, giving exit to an abundant flow of serum. Improvement at once set in, and every trace of œdema had disappeared in two weeks.—*Med. Record.*

#### The Obstetrics of the Kyphotic Pelvis.

Dr. CHAMPNEYS read a paper with the above title before the Obstetrical Society of London (*Lancet*), in which he gave an analysis of 32 labors in 20 women, including 3 labors in a patient of the author's, the last labor having been carefully observed. An analysis and a table were given stating the presentation, change during labor, measurements of foetal skull and pelvis, operative measures, moulding of foetal skull, result to mother and child. The conclusions at which the author arrived

were as follows; That vertex presentations, and especially right occipito-iliac positions, are unusually frequent; deep transverse position is common, posterior rotation not uncommon. The comparative frequency of occipito-posterior positions is probably due (as explained by Hoening) to the obstacle to forward rotation in third positions, which are very common. The head sometimes emerges from the ligamentous pelvis transversely, or nearly so, and entirely posterior to the tubera ischii. The analogy to the "extra-median" position was pointed out. The well known looseness of the pelvic joints in this pelvis, probably assisted this by the nutation of the sacrum. Spontaneous premature labor is not uncommon. The immediate foetal mortality in the published cases was 40.6 per cent., the maternal 28.1 per cent.; but the author thought this estimate probably too high, as slight cases were not recorded. The conclusions as to treatment and prognosis were: 1. In a first labor, if the head present, wait and act according to circumstances. This implies forceps, craniotomy, or Cæsarian section, which should always be considered in the above order. 2. If the head present, never turn. 3. In subsequent labors, where the history of the first labor seems to indicate it, premature labor may be induced with good hope. 4. No known measurements give us any sure indication for forceps, turning, Cæsarian section, or the date for induction of premature labor. 5. The mobility of the pelvic joints implies a prognosis always more favorable than measurements would lead us to suppose. 6. Probably in many cases the head entirely neglects the anterior half of the pelvic outlet, and emerges from it transversely, or at most obliquely, antero-posterior emergence being the exception. 7. Each succeeding difficult labor

increases the liability of the uterus to rupture, as in other forms of pelvic distortion.—*Med. Med. Jour.*

#### Hydrops Chorii.

Dr. JOHN MORRIS reports a case in July number of the *Medical Chronicle* which puzzled him very much, as he feared he had to do with some serious anomaly. After rupturing the membranes and an abundant discharge of waters, a shining blue cyst appeared at the vulva. After some difficulty he succeeded in finding the head of the child presenting normally above the brim of the pelvis. Just as the head emerged from under the pubis, this cyst suddenly burst, pouring its contents over the bed.—*Med. & Surg. Reporter.*

#### On the Use of Anesthetics during Labor.

In a paper recently read before the East Surrey District of the southeastern branch of the British Medical Association, THOMAS D. SAVILL, M. D., indicates what he believes to be the main precautions, the observations of which would render the use of chloroform perfectly justifiable:

1. There are certain women who have a tendency to flood at every confinement, and others in whom there seems an already too great relaxation of fibre—weak anæmic females in their eighth or tenth confinement; and to these it would be unadvisable to give chloroform, except for necessity. Happily, it is not these women who suffer the most pain, but rather those strong, healthy primiparæ whose pelves and general build approximate to the masculine type.

2. We should not give it when labor is complicated with severe vomiting, or with acute heart or lung disease, unless there be imperative call for it.

3. It should not be given to the full

extent, except for operation, convulsions, or spasm of the cervix; and then it is most necessary that one person should devote his entire attention to it.

4. The inhalation should be stopped directly we find the pulse becoming very weak or the respiration irregular.

5. Anything which makes us suspect a fatty or enfeebled cardiac wall should make us cautious in the use of chloroform. Here, as in cases other than those of labor, it is not the most extensive valvular disease (so long as it be attenuated by compensating hypertrophy) but the atrophied or degenerate wall that constitutes the source of danger. Unfortunately, the signs of these conditions are subtle and uncertain. Fatty heart may be suspected by an exceedingly feeble cardiac impulse, combined with an almost inaudible first sound; or attacks of dyspnoea, vertigo and syncope, in the absence of anæmia, or valvular lesion; or the copious deposit of fat in other parts of the body, and the occurrence of dropsy without adequate cause. A dilated heart may be suspected by increased area of præcordial dulness, combined with epigastric and venous pulsation, and a want of correspondence between the violence of the cardiac impulse and the strength of the pulse. Pericardial adhesions also form a great source of danger. They may be suspected when the heart's apex is fixed above its normal position, and does not shift with respiration; or when there is depression instead of protrusion of intercostal spaces over the position of the apex, giving a wavy character to the cardiac impulse.

6. In all cases we should take extra care to prevent the occurrence of hemorrhage after birth—by giving a full dose of ergot when the head reaches the perinæum; by ceasing the chloroform immediately it is born, and by rousing the

patient from her lethargy as soon as possible.—*Brit. Med. Jour.*

#### Puerperal Fever.

M. FISCHER has found, from experience in the obstetrical clinic at Prague (*Arch. für Gynæk.*, t. 20), that extreme prudence is necessary in the employment of antiseptic injections into the uterus. The attention of the accoucheur should be particularly devoted to the external genital organs, for it is often through an erosion of the vagina or vulva that septic materials find an entrance into the organism.

Fischer finds one simple washing out of the vagina in most cases sufficient. He employs tincture of iodine, permanganate of potash and a five per cent. solution of carbolic acid.

#### Laparotomy in the New-Born.

At a recent meeting of a medical society in Vienna (*Wiener Med. Blätter*) Dr. FELSENREICH showed a child, two weeks old, on whom he had performed a radical operation for the cure of umbilical hernia. The birth had been easy and natural, and the child itself was strong and healthy, with no other malformation. A tumor of the size of a lemon was situated in the abdominal wall, the umbilical cord being attached to its summit. The separation between the recti muscles was eight centimetres long and four centimetres broad, and contained intestines and the margin of the liver. Twelve hours after birth the operation was made in the usual way, the hernial sac being attached to the edge of the skin-wound, which was closed by twelve silk sutures, and dressed with iodoform. The operation was completed in twenty minutes, without much sign of pain on the part of the child, which took the breast immediately afterward, and had a normal stool on the second day. The progress of the case was very satisfactory throughout, although the healing of the skin was sometimes slow.—*Ibid.*

## DISEASES OF WOMEN.

**Hemorrhage in Gynecological Operations.**

At the last meeting of the American Gynecological Society, DR. ALBERT SMITH read a very valuable paper upon the use of hot water in arresting hemorrhage. The doctor did me the honor of referring to a lecture of mine, reported in the *New York Medical Journal*, on the above-named subject, and expressed his surprise that I did not allude to the use of hot water for the arrest of hemorrhage. That omission on my part was not due to any lack of appreciation of the value of hot water, but because I desired to bring before my class other methods of controlling hemorrhage, not sufficiently, if at all, given in our textbooks. It is better surgery to ligate a spurting artery, when it can be easily and safely done, than to depend upon hot water to arrest its bleeding.

The method of arresting hemorrhage by means of the pressure suture, which I described in the lecture, is also a valuable means. No one will see the truth of this more fully than my friend Dr. Smith, and I am sure no one can more highly appreciate the value of the doctor's paper than myself.

ALEX. J. C. SKENE.

**A Possible Result of Hot Vaginal Injections.**

DR. T. NAYLOR BRADFIELD (*N. Y. Med. Jour.*): A matter of much interest to me, and one which, if anywhere previously mentioned, I have failed to notice, is a possible consequence following the long, persistent use of hot-water vaginal injections.

A girl, twenty-three years of age, the subject of an hæmatocele extending from Douglas's cul-de-sac over and above the bladder to within three inches

of the umbilicus, was ordered hot carbolic-water injections, continued for an hour, and repeated no less than two or three times a day, the temperature never exceeding 100° F., or being allowed to fall below 90° F.

Six weeks succeeding the adoption of the hot vaginal injections the patient complained of increasing numbness down along the inner side of the lower limbs, with pain in the knees (notably the left), and a constant tingling of the toes, these symptoms gradually increasing until a week later, when the power to stand or walk alone was entirely lost, the patient, by great effort, being only able to hitch, or spasmodically drag her feet, when supported on either side by strong assistants.

Supposing the vaginal injections of hot water and the loss of locomotive power to have some near relation in the matter of cause and effect, the injections were discontinued for eight or ten days, with some return of strength and other decided improvements in the use of the limbs, a relapse into her former helplessness speedily following a renewal of the injections.

Dr. Thomas Addis Emmet, who had early confirmed my diagnosis of hæmatocele, was given a report of the case, with my views concerning the probable cause of the paralysis, which, as it appeared, was an opinion, however unreliable, somewhat original with myself. Dr. Emmet informed me that he had neither seen nor could remember any similar case, or, at least, where the use of hot-water injections had produced, or could reasonably be accused of producing, symptoms like those above described; and suggested as a more likely cause of the paralysis the great size of the tumor, and the pressure necessarily exerted upon the pelvic vessels.

A most reasonable objection to this

theory of causation (in the present case, of course) was the long time during which the patient was known to have suffered with this tumor (fully two years), and the absence of all symptoms prognostic of paralysis up to the time already mentioned, or, after the persistent use of hot vaginal injections for a period of six weeks, and when the process of softening, together with much improvement in the circulation of the pelvic vessels, was well begun.

The adoption of hot-water injections in the treatment of pelvic diseases having become almost universal in gynecological practice, the subject to which I call attention is certainly one of interest to the profession, and may, if my views appear reasonable in the case above cited, be studied with some benefit to our patients.

[DR. BRADFIELD raises a very interesting question, and one which ought to be noticed by gynecologists. Hot water is used so generally in all kinds of diseases of the pelvic organs that we may, at least, suppose that it does harm in some cases. We have not seen any such case as the one recorded here, but have frequently noticed that local pain was increased and evident harm done by the hot-water douch in some cases of pelvic cellulitis and peritonitis. A remedy so often used and so useful can be abused.]

A. J. C. S.

#### Uterine Polypi.

DR. WILLIAM GOODELL (*Buffalo Med. and Surg. Jour.*).

*Gentlemen*—I have often stated to you as a broad rule, that when a married woman, over the age of forty, who has borne children, comes to you giving a history of hemorrhage, the first thing that you should think of is carcinoma; and in nine out of ten cases that is what will be found. If, however, the

woman is unmarried, or if married, has not borne children, a benign tumor of some kind will in all probability be found. There may be occasional exceptions to this rule. Sometimes the bleeding will be due to a sarcoma, but this is rare, and may virtually be left out of consideration.

Here is a woman of about forty years of age, with an history that the monthlies became menorrhagic. When I pass my finger into the vagina, I feel in the os uteri a tumor, around which I can not pass my finger.

Polypi, probably all arise as submucous fibroid tumors, which start in the fibroid layer directly beneath the mucous membrane and grow in towards the uterine cavity, that being the direction of least resistance. Having reached the cavity, the peristaltic action of the womb in its endeavors to extrude the foreign body causes the formation of a pedicle. Polypi are therefore nothing more than pedunculated fibroid tumors of the womb. They may be found in three different positions: They may be (1) wholly in the vagina; (2) they may protrude from the neck of the womb, being partly within the cavity and partly in the vagina like the clapper of a bell; or (3) they may be entirely within the cavity of the womb. From the first situation they are easily removed except when very large. They may at times be almost as large as a child's head. Two years ago, I removed one which was so large that I had to make lateral incisions in the perineum, and even then there was a tear. After the removal she had all the evidences of having given birth to a child. When she left, I told her that if she had any trouble, she should write to me for a certificate of virginity, for previous to the operation I found a complete hymen. After she went home, there were

such whisperings among the old women of the village, that I had to write out the certificate,

When the polypus is in the vagina, our plan is to twist it off, or if it is large, to remove it with the wire *écraseur*, or even piece-meal, in the best way we can. If it is dangling from the mouth of the womb, we do the same thing. When, however, the polypus is in the cavity of the womb, the direction given in the old English recipe for making hare soup is applicable, "first catch your hare." So here, one must first catch the polypus before one can remove it. The first thing is to determine whether or not there is a polypus inside of the womb; we have to infer it from the length of the womb; the sound will sometimes tell at once. In order to be certain, you dilate the cervix by sponge tents and pass in the finger; if you discover a polypus, you must redilate the canal, if you have not already done so sufficiently, and then catch hold of it with the polypus forceps. This is a most valuable instrument; if I could not get its counterpart, I would not part with it for its weight in gold. In removing a stone from the bladder, you know that the instrument is passed and the stone caught at haphazard. In polypus of the uterus, the same thing can often be done. I have frequently twisted off a polypus in the cavity of the womb when I did not know positively that one was present. The forceps have only to be opened to the width of the polypus, plus the thickness of the blades, which is very slight. If the volsella forceps are used, the blades have to be separated fully half an inch more than the thickness of the tumor, in order that its fangs may secure it. This instrument, which is the one frequently advised, has other disadvantages; the womb may be

caught instead of the tumor; and further, if after you have caught the polypus you find that it is tearing, it is a difficult matter to release it without injuring the womb. The fenestrated polypus forceps is therefore the instrument to use.

I have told you the three positions in which polypi are found, but there is a word of caution to be given. A polypus may be exactly mimicked by an inverted womb. Such wombs have been frequently removed, and that by the best surgeons, under the impression that they were polypi, for it is often difficult to determine whether a tumor projecting from the cervix of the womb is a polypus or an inverted womb.

How are you to decide? What are our landmarks? Inversion of the womb is rare; polypus is not rare. An inverted womb is small; a polypus is often large. An inverted womb may, however, be large because it has in its wall a fibroid tumor. An inverted womb is sensitive; a polypus is not. If, before the patient is etherized, you pinch or squeeze an inverted womb, pain will be complained of, but if the polypus is pinched, or a pin stuck into it, the patient will not flinch. An error may come in here; that is, a fibroid tumor covered with mucous membrane might be extruded. The membrane is supplied with nerves, and any injury to it would cause pain. In such a case, the error would be on the safe side, for if the tumor were sensitive, you would perform no operation until you were thoroughly satisfied that the body was not the womb. Inversion of the womb is exceedingly rare in virgins and it is not at all common in married women. I have never seen an instance in a virgin. It usually occurs as the result of labor, and is recognized at the time. It is then either replaced or the woman

dies. The sound will aid in the diagnosis. There will not be a uterine cavity in inversion, but if the womb measures two and a half inches, you may be sure that there is no complete inversion. Here comes a difficulty, and here it is that the best surgeons, and the most excellent diagnosticians, have made the mistake of removing a portion of the womb together with the polypus. The womb in trying to extrude the polypus, may become cupped, like the bottom of a wine bottle. The traction made by the surgeon will often do the same thing. He applies the wire of the ecraseur to what he supposes to be the pedicle, when in fact he has noosed the cupped portion of the womb which is removed with the tumor. It is not always easy to determine whether this cupping has taken place or not. You would be astonished to learn how many good surgeons have removed a portion of the womb with a polypus; many cases have not been reported, for if the result be fatal the case is less likely to be reported. On the other hand, I believe that in many instances a part of the womb has been removed, without the knowledge of the physician, who wondered why his patient died. In the present case, I have not been able to decide whether the tumor is a polypus or an inverted womb, for when I attempted to pass the sound, I could not discover a uterine cavity. I said to this patient, "now I want you to tell me one thing, have you ever borne a child?" This made her quite indignant and from her expression I feel certain that she is a virgin. To-day she is under ether, which makes matters easier.

I shall try to draw the womb down. This will facilitate diagnosis. The pedicle is either fastened to the sides of the os by inflammatory lymph, or else

some portion of the womb is inverted. If the woman is a virgin, as I believe she is, the latter is hardly possible, but it does sometimes occur. I tried to pass the sound in my office, but did not succeed; but I have now broken an adhesion, and the sound enters three inches into the cavity of the womb. I also feel the fundus above the pubes. My conclusion, therefore, is that a fibroid tumor has gradually been forced from the wall of the uterus into its cavity, and thence into the vagina, without becoming pedunculated. From the measurement given by the sound, I know that the greater part of this tumor is outside of the womb, but it is impossible to say where the tumor ends and the womb begins. I shall, therefore, try to enucleate the tumor. It is covered by mucous membrane. I slit this membrane and strip it off. In this way, I shall take out the tumor without injury to the womb. It comes off, you see, with some degree of ease, but not as readily as the rind from an orange. This is precisely the way in which fibroid tumors within the cavity of the womb are enucleated. Where no pedicle exists, this is the safest way of operating. In enucleating a tumor inside of the uterus I use an Adam's subcutaneous saw to make an opening in the most projecting part of the tumor. I prefer the saw, because it is easier to manage in such cramped quarters than the scissors or a probe-pointed knife. Further, the bleeding is less, and points can be reached by it that are inaccessible to the other instruments. I make an opening into the capsule as large as possible, sometimes not more than an inch, sometimes two or three inches in length. I then pass my finger and peel off the mucous membrane as far as I can. If possible, the tumor should be removed at one sitting; but if this can-

not be done, ergot should be given to induce contractions of the uterus. In a few days the little wound will be forced open by the tumor, and you can then proceed with its enucleation.

I have now removed the tumor. It was not pedunculated, but, as I said, it is a fibroid in the process of self-enucleation. I have simply completed what nature had begun. I shall now examine the womb to see whether it has been at all inverted. It is not; and as there is no bleeding, I shall do nothing more. Should bleeding occur in such an operation, vinegar is the best hæmodynamic. I never use Monsel's solution unless driven to it by an alarming hemorrhage. The objections to it are that it produces plaster-like clots; these remain inside of the womb, break down with a bad odor, and are liable to cause septicæmia. It is not a safe hæmodynamic in regions where the tissues are erectile, as about the womb. In such situations the veins and lymphatics staying open are more likely to absorb septic material than in any other portion of the body where these vessels contract after being cut. Another objection to the use of Monsel's solution is that it so corrugates and contracts the vagina as to interfere with the needful manipulation. Do not, therefore, use Monsel's solution in operations on the womb. I have often used it in cancer of the cervix, and have never had any bad results, for in this condition there are friable granulations which need corrugation. As this patient will remain in the hospital where she can be watched by the physicians and nurses, I shall not plug up the womb. If I performed this operation in the country where I could not see the patient for several hours, I should cram a sponge into the cavity which formed the nidus of the tumor. I do not like to plug the womb

because the blood collects behind the plug, and clots. In a few hours it begins to putrefy and give off an odor; in twelve hours the smell is more decided, and in twenty-four it is exceedingly offensive.

There is another variety of polypus of which I neglected to speak. It is a small affair, which might seem to you insignificant; and yet has destroyed life. I refer to an enlarged nabothian gland which has become pedunculated. It will be found either partly within the canal and partly without, or just within the os uteri. The finger will usually detect it, but being very small, it sometimes retreats within the canal before the examining finger, and the speculum may be necessary for its discovery. Women have actually bled to death from the presence of a small mucous polypus, or a pedunculated nabothian gland, not larger than a pea.

The after-treatment of our patient will be simply to keep the patient sweet and clean by vaginal injections of potassium permanganate. Her bowels will also be kept bound for a few days, and she will stay in bed until all vaginal discharges from the sore have ceased.

[While the foregoing lecture has our endorsement, we object to the practice of incising or tearing the perinæum in order to deliver a polypus. It would have been vastly better to have removed the tumor in sections. In all such operations, great care should be taken to avoid injuring the uterus, vagina and perinæum, because open wounds expose the patient to blood-poisoning from the discharges which are likely to occur after the operation.] A. J. C. S.

#### Total Extirpation of Carcinomatous Uterus.

SAENGER, of Leipzig, reports (*Sep. Abdruck Archiv f. Gyn.*, B. xxi, H. 1) two cases of successful extirpation of the

uterus through the vagina, for malignant disease. The first patient, 51 years of age, suffered with ulcerative carcinoma of the cervix uteri; the operation of Czerny and Schröder was performed, and was followed by considerable hemorrhage, which continued after ligation *en masse*, and only ceased after the application of a tampon. Four months afterwards cancer returned, and in the course of a few months later an intestino-vaginal fistula developed, and the patient finally perished of exhaustion, ten and a half months after the operation. The second case was 36 years of age, and had a commencing cancer of the cervix. The uterus and both ovaries were removed, and the patient made a good recovery. Six months after the operation, the patient appeared entirely well, with her general health greatly improved and no sign of a return of the disease.—*Med. Med. Jour.*

#### Tumor.

Dr. MORITZ SCHUSTLER reports the following interesting case from Billroth's clinic (*Lancet*). A married woman who had had six children and one miscarriage had suffered from the following symptoms for four years: Intense pain in the hypogastrium at intervals, gradually growing worse, accompanied by fever and tenderness; later, shortness of breath and palpitation of the heart, frequent micturition and constipation. A tumor was first noticed five months before the operation, in the left side, the size of an apple, which grew rapidly, so that at the time of the operation it reached almost to the false ribs. Loosely connected with it was a second tumor to the right, and not so large as the first. There was only slight mobility, the surfaces were nodulated, there was no fluctuation. The uterus seemed pushed to the left side and behind. The operation

was done without spray, but under strict antiseptic precautions. On reaching the tumor and attempting to lift it out of the abdomen, it was found to be closely adherent to the upper part of the posterior wall of the bladder. As the tumor seemed to be malignant, Prof. Billroth decided to excise the adherent portion of the bladder, and a piece three centimetres long and two centimetres broad was removed. The wound was closed by six fine silk sutures. It was then found that the posterior surface of the tumor was so firmly adherent to a part of the small intestine that it could not be dissected off. A piece twelve centimetres long was therefore cut off, and the two ends of the severed intestine joined by fourteen sutures, five internal at the insertion of the mesentery, and nine for the rest of the circumference. The rest of the operation presented no especial difficulties. The convalescence was undisturbed by any complication. Flatus passed on the second day, and on the sixteenth there was an operation of the bowels following an enema. The catheter was used for the first few days only. On the twenty-fourth day the patient left the clinic well. According to later accounts the woman is in perfect health; and fifteen months after the operation there has been no sign of a recurrence.

#### The State of the Uterine Mucous Membrane during Menstruation.

Besides WYDER (*Ztschr. f. Geburtsh. u. Gynäk.*, ix., 1), the names of Kundrat, Engelmann, Williams, Leopold, Möricke, and de Sinéty may be mentioned among those who have made investigations upon this subject. All of them agree that the uterus is deprived of its epithelium during menstruation, and is converted into a wound-like surface. The disagreement is as to the extent of the

exfoliation. Williams concludes that there is a complete loss of the mucous membrane of the uterine body and a laying-bare of the muscular tissue. Kundrat, Engelmann, Leopold, and the author are of the opinion that only the superficial layers of the mucous membrane are shed. The four authors first mentioned believe in a fatty degeneration of the menstrual mucous membrane, all but Leopold considering it as the primary and principal factor in producing the hæmorrhage, while Leopold, on the other hand, considers it (the fatty degeneration) as secondary to and dependent upon the hæmorrhage, the latter being caused by excessive dilatation of the capillaries of the uterine mucous membrane, with relative insufficiency of the veins. Regeneration takes place, according to the author, from the layers which have not been shed, and which are in a condition of cell hyperplasia. Neither Möricke nor Sinéty admits that there is loss of mucous membrane during menstruation, or fatty degeneration, to a very great degree, the process being largely limited to congestion and diapedesis. The author proceeds to the analysis of eight cases, with special reference: 1. To the condition of the superficial and glandular (uterine) epithelium; 2. To the kind of hæmorrhage which occurs during menstruation and the method of its occurrence; 3. To the condition of the mucous tissue, particularly the interglandular substance. He accords to Möricke the credit of having established the following points: 1. That during menstruation a portion of the mucous membrane of the body of the uterus is undisturbed; 2. That the teaching of Kundrat, Engelmann and Williams concerning a primary fatty degeneration of the uterine mucous membrane is no longer tenable; 3. That the superficial and middle

layers of this membrane do not suffer conversion into a decidua. His own views are summarized as follows: 1. During menstruation a portion of the superficial layer of the mucous membrane disappears, the rest remaining. This shedding process varies in extent in different cases, now involving the entire superficial layer (Leopold, Wyder), again taking only a small portion of it (Spiegelberg). The elements which are thrown off are partly detritus and partly undecomposed matter. In some cases, dysmenorrhœa membranacea, small mucous shreds are found, which, however, are too small to cause dysmenorrhœa. 2. This process of shedding is caused by the hæmorrhage of menstruation, and not by primary fatty degeneration. 3. The superficial and middle layers of the mucous membrane, which are left behind, show an abundance of small cells, but no similarity to the decidual membrane of pregnancy. The deepest layers show a cell-hyperplasia of the interglandular tissue, the evident mission of which is to furnish a supply for the tissue which is lost during menstruation. 4. The degeneration of the superficial epithelium is participated in, as well by the glands as by the surrounding membrane in which they are embedded.—*Ibid.*

#### DISEASES OF CHILDREN.

##### Tetanus Neonatorum Treated with Bromide of Potash.

Dr. L. EMMETT HOLT, of New York, reports in the *Boston Medical and Surgical Journal* a case of tetanus in an infant, aged seventeen days, which was cured by the use of eight grains of bromide of potash every three hours. After a review of the literature of tetanus neonatorum, Dr. Holt finds that the

following methods of treatment are recorded: "castor oil and local sedatives; quinine and morphia endermically, nothing by the mouth; cannabis indica in full doses, that is, one-half ounce of the tincture per diem; ipecac and quinine in small and frequent doses; atropia hypodermically; sulphate of zinc in five-grain doses every three hours, and a 'little opium'; chloral in doses of one grain or two grains four or five times a day; postural treatment alone, no medication."

He divides cases of tetanus into three groups: (1) Those acute severe cases which prove fatal in from one to three days in spite of all treatment. This class includes, unfortunately, the great majority of the cases. (2) The very mild ones which tend to spontaneous recovery. (3) Those which are less acute than the first series, but still severe, in which recovery seems to be due to the treatment employed. He classes his own case among the last mentioned. Up to the beginning of treatment the case had been growing steadily worse. Eight grains of the bromide were taken every three hours, night and day, for five days. Inside of thirty-six hours there was such improvement that the child took the breast for the first time in a week. At the end of five days, when the child was so much better that the dose was reduced, a decided exacerbation in the symptoms followed, which lasted until the larger doses were resumed.

#### **Treatment of Croup by Sulphide of Calcium.**

In a communication read before the Medical Society of Rheims (*Union Médicale du Nord-Est*), Dr. MEUNIER reported upon a number of cases of croup treated by sulphide of calcium in doses of three to four and one-half

grains per diem. The remedy was given in granules of one-tenth of a grain each, one or two granules every hour. The author regards the sulphides as of great value in the treatment of diphtheria and croup, while not being, strictly speaking, antidotal to the specific poison of the disease. Their mode of elimination, in great part by the pulmonary mucous membrane, is a further recommendation for their use. Dr. Meunier's success in the cases recorded was not startling, yet was such as to warrant further trial of the sulphide of calcium in this disease.

#### **Bathing Infants in the Sea.**

At the present season a mistaken and mischievous practice is much in vogue. Daily torture is inflicted on thousands of tender and helpless infants by forcibly plunging their bodies, in spite of shrieks and struggles, into the open sea. This cruel and time-honored process may now be seen in full operation at any sea-side resort. Affectionate mothers hand over their infants to stalwart and impassive bathing-women, to be plunged head foremost into the sea, under the absurd notion that the procedure vastly benefits the little ones. Day after day, with relentless regularity, very young children and babies are borne out amid the waves and subjected to their dreaded ducking, in the firm belief that their trembling bodies, often writhing to the verge of convulsions, are thus made healthy and hardy. All experience on the subject, and the teachings of all medical authorities on sea-bathing, agree in support of the two following rules—namely, that a child under two years of age ought never, under any circumstances, to be bathed in the open sea; and that no one, child or adult, can enter the sea without danger while under the influence of emotional excite-

ment. Under two years of age, a child's body is too weak to gain any benefit from the shock of immersion in the open sea. Its nervous and circulating forces are too feeble for the development of that vigorous reaction without which sea-bathing is either useless or hurtful. In the absence of strength for such reaction, a sea-bath tends to chill an infant's body, and predisposes to internal congestions. At any age, the shock of immersion in the sea brings risk of danger, and even of death, when the emotions are powerfully excited, and especially when the mind and body are dominated by that most depressing of human emotions—fear. Infants are not always bathed in the sea merely with the intention of making them strong. There is an old sea-side tradition that babies diligently bathed become fearless in the water when they grow up. This notion is also false. Than that infants gain courage by being plunged in the sea, it is more probable that many a nervous child has acquired a dread of bathing which no after-experience could remove, because it was compelled in fear and trembling to plunge under water. If a child be sufficiently robust to develop a good reaction, if it be over two years of age, and, above all, if it be not afraid, it may be bathed in the sea with advantage. If any of these conditions be wanting, sea-bathing for children is likely to be positively injurious. —*British Med. Jour.*

#### Croton-chloral in the Treatment of Whooping-Cough.

Dr. W. C. WEBB, of Bryantsville, Ky., (*American Practitioner*), has come to the conclusion, from the treatment of nearly two hundred cases of whooping-cough, that croton-chloral is by far the most valuable single remedy for its relief. He

has found that it is well borne by children. To affect the disease it must be given in decided doses. A child twelve months old will bear one grain of the medicine every four hours throughout the twenty-four. During the first week not less than this should be given. Thereafter, the cough is usually so much relieved that few if any doses are required at night. If the drug be thus pushed to its full effect, there are few cases that may not be entirely controlled in a fortnight. The dose for children ten years old should be two grains every four hours; adults will bear only about four-grain doses. The drug thus used does not derange digestion or affect the vital nervous centers. The first few doses may cause some irritation about the throat and fauces, but this soon ceases. The relief is so marked in some cases that patients fall asleep in their chairs.

Croton-chloral, if pulverized, will dissolve readily in compound tincture of cardamon. The following is a good prescription:  $\mathcal{R}$ . Croton-chloral,  $\mathfrak{z}$  i; tinct. cardamo., glycerin,  $\text{āā}$   $\mathfrak{z}$  ij.  $\mathcal{M}$ . Sig. One-half teaspoonful every four hours, for a child two years old and under. A less expensive and very useful mixture is as follows:  $\mathcal{R}$ . Croton-chloral,  $\mathfrak{z}$  i; tinct. belladonnæ,  $\mathfrak{z}$  ij; tinct. cardam. co.,  $\mathfrak{z}$  ij; glycerin,  $\mathfrak{z}$  iij.  $\mathcal{M}$ . Sig. Dose, one-half teaspoonful. If the paroxysms of cough are exceedingly severe, and if there is extreme gastric irritability, the croton-chloral should be preceded by a few whiffs of chloroform. The anæsthetic thus used produces the happiest effects, and it need not be repeated more than two or three times. The combination of bromides with the croton-chloral is of doubtful utility. If any of them are to be used, the bromide of quinine should be preferred. Watchfulness should, of course, be exercised

during the use of croton-chloral, lest toxic symptoms should be manifested.

—*N. Y. Med. Jour.*

#### Carrying Children.

In carrying children in the arms care should be taken not to carry them habitually on the same side, as this tends to make them one-sided, a condition that may be frequently observed in all the children of a mother who can nurse only from one breast. Not only the bodies but the heads and faces of a whole family can sometimes be drawn over to one side. The only remedy is to change the position frequently, a very difficult thing for such mothers to do, but something that good-will and attention can accomplish.—*Weekly Med. Review.*

#### Bismuth in Dyspepsia of Children.

Dr. E. W. DUNBAR (Zurich), contributes the following to the *Practitioner*:

Loss of appetite in children with pain after eating, nausea, and depression, if accompanied by a tongue either clean or slightly coated, but showing redness and enlargement of the papillæ fungiformes, is quickly relieved by administration of bismuth, either in the form of the subnitrate or of the solution of the oxide in ammonia and citric acid as discovered and prepared by Mr. Schacht. The dyspepsia, which is characterized by the described appearance of the tongue, is produced by indigestible food. If the tongue is coated the dyspepsia is recent; and it is chronic and of some duration if the tongue is clean, loss of appetite and consequent diminution in the amount of food taken having given opportunity for the tongue to clean.

The digestion of children being easily disturbed, this form of dyspepsia may very frequently be observed among

them. It is often necessary to persist in the use of bismuth for several weeks before the papillæ fungiformes resume their normal appearance and a lasting cure is effected, although improvement shows itself quickly in the appetite and returning liveliness and cheerfulness of the little patient. The action of bowels is as a rule markedly improved and more regular, especially if the liquor bismuthi is used; exceptionally the bowels are rendered more constipated, and it is necessary to give a mild aperient occasionally.

While testing the accuracy of the described indication for the use of bismuth I prescribed it, owing to the state of the tongue, in the case of a child who had an obdurate cough that had resisted all the usual remedies for subduing irritation of the larynx. The cough ceased with the improvement which quickly succeeded the dyspeptic symptoms. The dullness and languor produced by this form of dyspepsia in children may easily be mistaken, especially if the tongue is clean, for weakness and a condition requiring tonic treatment. The marked distaste for food and the characteristic tongue point to the true nature of the ailment.

The dose of liquid bismuth varies from two minims under one year, to three, five, ten, fifteen, and twenty minims up to twelve years of age; the dose to be repeated twice to four times a day according to the severity of the symptoms. The remedy appears to be most effectual when taken after meals. The subnitrate may be given in doses of one-half grain up to two, three and five grains.

Bismuth is quite ineffectual in the dyspepsia of children where the tongue is smooth, clean and shows no enlargement or redness of the papillæ fungiformes.—*The Cincinnati Lancet and Clinic.*

**Lactopeptine in Gastric Disorders of Children.**

DR. AUBREY HUSBAND (Medical Officer to Royal Dispensary, Edinburgh): Of all the disorders to which young children are liable, those affecting the digestive organs are at once the most common and the most fatal. It has been calculated, from the Registrar-General's report, that one-quarter of the deaths among children under five years is due to diseases of the digestive organs, and this fatality is considerably greater under one year. Passing from these general considerations I would specialize one or two diseases which, from their constant recurrence, cannot fail to attract attention, and in which I was enabled to watch the effect of Lactopeptine.

The cases are those of rickets, and of so-called atrophy with dyspepsia and diarrhœa. The following cases are of this type:

1. C. D., æt. 3. The little patient had all the symptoms of rickets. She had a heavy, stupid look, the chest much contracted laterally, and the bones of both legs and arms much affected. She was ordered 5 grs. lactopeptine after each meal, and under this treatment the child gradually, and then rapidly, improved.

2. M. W., æt. 2. The child was found suffering with symptoms of gastric derangement, colic, vomiting, and loss of flesh. As the diet had always consisted of anything that could be obtained, from dried cod and cheese, and as there was no chance of providing more suitable food for the child, it was hoped that by the aid of lactopeptine the diet might be made more digestible and nourishing. Accordingly 5 grs. lactopeptine was given daily after food, and the result was more favorable than was expected—the little patient after a short period becoming quite well.

3. J. M., æt.  $7\frac{1}{2}$  years, was evidently of strumous habit, losing flesh rapidly, felt pain after taking meals. He could not take cod-liver oil. There were no chest symptoms. He was ordered 5 grs. lactopeptine three times daily, which was continued for a month, when he was able to take the oil, and speedily recovered.

The above cases serve to demonstrate the value of lactopeptine in the treatment of gastric disorders of young children. In two cases of children of a mother in the last stages of phthisis, the lives of the babes were saved by its use.—*The Medical Press and Circular*.

**Diabetes as a Symptom of Intracranial Disease.**

A child four and a half years old, previously healthy, had for nine months experienced constant thirst and increased excretion of urine without nervous phenomena, but the patient lost flesh and became gradually weaker. At this time the symptoms of tubercular meningitis developed, and she died after a fortnight's stay in the hospital. The quantity of urine was very great—on one day it was nearly ten litres. At the autopsy, besides a tubercular meningitis, there was particularly observed a caseous tubercle of the infundibulum and a spot of softening in the corpus striatum, with distention of the lateral and fourth ventricles.—*Md. Med. Jour.*

**Hypophosphites and Children.**

DR. H. CULLIMORE thinks that the hypophosphites should not be given to children between the ages of four and seven if they are at all precocious and inclined to too much mental activity.

## OBSTETRICS.

**Head-first Delivery in Placenta Previa.**

We find in the *Planet* a communication from Dr. T. S. ESHLEMAN on the advantages of head-first delivery in cases of placenta previa, instead of delivery by turning.

The recommendation is briefly to deliver by the forceps instead of by turning, "to use a narrow blade forceps, say  $\frac{3}{4}$  inch in width (across the fenestra) for the first blade; the second blade may be  $\frac{3}{4}$ , as it must pass over the shank of the blade first introduced. The blade of the ordinary long forceps will readily enter the os, as this latter is usually found relaxed in consequence of hemorrhage. An examination made by one finger will usually determine the direction of a free edge of the placenta in the "partial cases"; central implantations are rare. A second finger will make sufficient dilatation of the os for the introduction of the forceps. There is no time or occasion for tamponing in these cases.

[The doctor considers that in very many abortions the condition of p. previa exists, but is overlooked by the attending accoucheur and nurse. He also firmly believes that this obstetrical presentation is not essentially dangerous. Certainly this is very different to what we are usually taught and led to believe. Dr. E. says there is usually no time to administer an anæsthetic; so he applies the forceps at once without previous medication, having in view the relaxation of a rigid os: as regards *waiting* for the os to be relaxed in a natural way, he states that is useless and dangerous; when the blades are locked he uses traction, alternating with short periods of repose; as the very fact of the presence of the forceps acts as a stimulus to

the uterine fibre, and induces partly a natural expulsion of the fœtus.]

If the implantation be central, go through it carefully with the fingers, or a pair of speculum (dressing) forceps, closed; you will usually find one or more apertures [closed fissures. Ed.] extending to the free membranous surface of the placenta; you penetrate these openings forcibly by the forceps; you will thus make a complete opening of about two inches, which will admit the blades of the obstetrical forceps. A little manipulation will readily grasp the head. This done, tilt the handles back against the perineum; this will throw the fœtal head against the abdominal walls of the mother; when the hand, externally applied, while turning the head from side to side with the forceps, will determine the proper adaptation of the blades on the fœtal head, for the fact of any projecting of the points, the child's head being small, might injure the mother. The head is now brought down firmly upon the placenta, *which instantly arrests all hemorrhage.* The labor will then be conducted as an ordinary forceps case, by traction, alternated with rest, to which the uterus will respond, and this method will generally insure contraction after delivery. If the child is alive when the accoucheur arrives, aided as he will be by the previous hemorrhage producing a general relaxation, and by the usual smallness of the child, from its premature birth—he will be able to deliver it alive, even should the placenta become entirely separated, or the pressure of the head cut off the circulation in the placenta during traction.

[Dr. E. states that the child will live even half an hour after the placenta has been detached. The doctor further states that since he has adopted instrumental interference in the cases of chil-

dren alive on the arrival of the doctor he has invariably delivered living children; whereas as usually conducted, dead children are brought into the world—the object of the accoucheur being simply to save the mother.—Ed.]

It is well to follow the emptying of the uterus by manipulations externally applied, to insure contraction and prevent inversion; and even after delivery to keep it up for some time. The cold douche may be required on the abdomen, while the hand is kept within the uterus. After delivery, if suspended animation is present in the child, place it in a warm bath, at the same time making use of artificial respiration. The accoucheur must not leave these cases to the care of the nurse, either before or after delivery, even for several hours; he will find enough to do, aided by the nurse; an assistant should also be present. The child must be resuscitated by an assistant, even though it take half an hour. And, in the case of the mother, every means to prevent syncope of heart-clot in extreme hemorrhage must be employed, such as stimulants and fluid drinks; while the shoulders and head of the mother are diligently kept down every moment upon the mattress, and the foot of the bedstead should be very much elevated.

The writer's views and treatment have been given from time to time, in discussions, and papers read before the Philadelphia County Medical Society, and published with the Transactions in the *Philadelphia Medical Times* and other journals. Dr. Davis, of Wilkesbarre, impressed by these papers, was led to adopt the recommendation mentioned therein. He read a very interesting and important paper at the Centennial Meeting of the Pennsylvania State Medical Society, describing eight or ten cases which he had treated. A majority

of the children and all the mothers were saved. This paper was published in the Society Transactions for the (centennial) year, 1876. He asserted that Dr. Eshleman's method must revolutionize the treatment in placenta previa.

*Summary.*—Some of the advantages claimed for the forceps so used, over "turning," in p. previa, are: 1. That the delivery is head-first, insuring greater safety to the child. 2. That the forcible introduction of the hand is avoided by their use. 3. That valuable time is saved, as the blade of the forceps requires but half the dilatation of the os, that the hand does to introduce. 4. That the placenta is less disturbed in its attachments. 5. That hemorrhage is not so apt to accompany the introduction of the forceps. 6. That hemorrhage is instantly arrested by traction on the forceps causing the head to press upon the placenta. 7. That distension is made to accommodate the hand in the uterus, and incident to turning; while passing the longer diameter of the child across the shorter diameter of the uterus is avoided. 8. Greater safety to the mother. These may be multiplied by further reflections.—*Buffalo Med. Jour.*

#### The Duration of Pregnancy.

A. F. C., in the *American Journal of Obstetrics*, quotes and comments upon the opinions of J. Veit (*Zeitsch. f. Geb. u. Gyn.*), as follows: Two hundred and eighty days have been commonly accepted as the average duration of pregnancy, by which term is intended the interval between the last menstruation and the delivery of the fetus. It is desirable to be able to fix upon the day when pregnancy is established, and in order to do this it is necessary to know whether the fertilized egg is a product of the last menstrual period or of the

first period which is omitted. Many statistical tables are cited, giving the average duration of pregnancy observed in different countries, and by different men. As these tables vary by as many as thirty days above and below the commonly accepted two hundred and eighty days, they are not of much value. The author thinks that the explanation for the variable period of time which intervenes between the first day of the last menstruation and the birth of the fetus is to be found in the causes by which labor is established. Three questions naturally arise in studying the subject of the duration: 1. What is the relation of ovulation to menstruation, as to time? 2. How long will the spermatozoa retain vital activity. 3. Does ovulation occur only with menstruation? The last two questions are considered to have been answered in the statement that there can hardly be a doubt but that the spermatozoa will remain active from the end of one menstruation until the beginning of the next; likewise that the labors of Bischoff have shown that ovulation usually follows menstruation. Before the establishment of the last observed menstruation, seminal fluid may be present in the genital canal, which will be the fertilizing element for the ovum which appears with menstruation. A second possible means of impregnation lies in the fact that the ovum may have been deposited upon the uterine mucous membrane at the time of menstruation, and have been fertilized after a subsequent coitus. A third possibility is that the ovum may appear before or at the beginning of menstruation, be fertilized at that time, whereupon menstruation will stop and decidua begin to form. Which of these three theories is the correct one, the author is unable to say. The conclusion, on his part, is that we are not, at present, able to say

whether impregnation occurs at the time of the last menstruation or at the time of the first one which is omitted. We therefore remain in the same uncertainty with which we started, and must continue to estimate the duration of pregnancy only approximately.

#### Delivery of Hydatid Moles by Expression.

Dr. GREGORIC advocates a new method for the treatment of hydatid moles (*Allgemeine Wiener Medizinische Zeitung*). When the diagnosis is definitely made, uterine contractions should be induced by a vaginal tampon and subcutaneous injections of ergotine. Then, as soon as the os is dilated for about an inch, the contents of the womb are to be forced out by Crede's method. This need not be done rapidly, but may be practiced repeatedly at short intervals. The mole is squeezed out through the vagina, as the author expresses it, like a sausage. The uterus quickly contracts, and the hemorrhage ceases.

#### Massage with Successful Results in Phlegmasia Alba Dolens.

KOCHMAN, Strasburg.

Frau Shaw, convalescent from puerperal fever, again became suddenly sick on the evening of the 30th January, 1883, with the appearance of fever and pain in the left leg, which increased toward morning. K. found upon examination, February 1st, temperature 101.3° F., pulse 96, the left leg very edematous throughout its entire length and very painful, under Poupart's ligament in the fossa navicularis a hard tumor, the size of a pigeon-egg.

The diagnosis was phlegmasia alba dolens as a result of thrombosis of the crural vein. Departing from the usual mode of treatment, with the exception of a laxative favorable in all such cases,

the author employed massage with remarkable results. First, the left leg was laid upon an inclined plane, with the feet higher than the head. Then K. kneaded the limb, beginning with the foot, at first with a gentle pressure, later somewhat more energetic, always paying special attention, however, to the inner muscles of the thigh, to the adductors, which had become as large as painful, and by their increased weight pulled upon the tumor. Upon them, massage was made from below and within, upward and outward, and afterward the whole were raised so high by means of a sand-bag placed beneath that they were somewhat higher than the femur and the tumor formed by the thrombosis of the vena cruralis. In consequence of the relaxation of the swollen adductor and skin, thus produced, circulation was better, and the pain which had been very great ceased.

Surprised at the result of the first trial, Kochman kneaded the limb a second time the same day, following the massage, however, by a Priessnitz bandage; he raised the foot upward with care, bandaging it with bandage a hand-breadth in width, then covered it as closely as possible with silk, and ended with a padded bandage. The next morning found bandage and bed dripping wet; the swelling had gone down to a remarkable extent in the leg; only the adductors presented edema, and they only to a slight extent. While the patient remained quiet there was no pain and temperature was normal. The tumor had decreased to a marked degree, and the author now ventured to gently knead as he had not done before, lest emboli should be formed. In the evening the same treatment was repeated, and a cup of inf. herb. jaborandi was given to promote perspiration.

On the fourth day after the beginning

of the treatment the patient was out of danger; no pain, and the tumor only one-third its original size. To-day, after twelve days, the tumor has entirely disappeared; the patient has gotten up and walked about with the aid of a cane. General condition good, color has become fresher, and strength increasing.

While the author recommends this method, it must not be forgotten that massage of the thrombotic spot demands extreme care and should only be made after the third sitting, and then very gently, so as not to give cause for the formation of an embolus by breaking the point of the thrombosis projecting into the vessel.—*American Practitioner*.

#### **Extra-Uterine Pregnancy, with Retention of the Fœtus for Seven Years.**

A woman thirty years of age, during the second month of pregnancy, was suddenly seized with violent pains in the lower part of the abdomen, followed by syncope, cold extremities and vomiting. These symptoms indicated the commencement of a peritonitis, which lasted for three weeks. The pregnancy then proceeded without any further accident. About two weeks before the expected time, the pains of labor began, and recurred with regularity and increasing frequency. Even the os began to dilate. Suddenly, after three days, all the pain ceased, the os closed again, and the patient resumed her ordinary avocations. She experienced a little inconvenience at first from an abundant secretion of milk. Six weeks later menstruation was re-established, and for seven years the courses appeared with perfect regularity and the woman enjoyed excellent health. At the end of this time another attack of peritonitis confined the patient to her bed for

several weeks, during which illness she passed a quantity of hair mixed with the fæces. Five months later she began to pass little bones with her stools, and in the course of three months very nearly a complete foetal skeleton was thus collected. The bones were perfectly clean of the soft parts. They were in a more advanced stage of ossification than is normal in a child at term. At the time that this case was reported to the Anatomical Society at Paris by Dr. De Brun the woman was in excellent health, and still passing one or two perfectly formed bones with each stool.—*Le Progrès Médical*.—*Med. Record*.

#### Occipito-posterior Cases.

DR. CHARLES ROBERT THOMPSON thus treats these cases (*Brit. Med. Jour.*): I have for many years adopted the plan of delivering these cases with the whale-bone fillet. The position of the head being exactly ascertained, the fore and middle fingers of the left hand are passed up until the posterior fontanelle is reached, and if possible, are pressed against the occipital bone. The fillet, held in the right hand, is compressed and advanced gently along the left palm and palmar surface of the fingers till it rests on the head. It is now allowed to expand, and is guided upwards and directed by the fingers until it is felt to embrace the occiput, on which it is generally possible to obtain a firm purchase. Gentle traction is then made during each pain, the fingers of the left hand being still on the head to inform the operator of its exact position; the occiput is brought down, the forehead recedes, expulsive pains are immediately excited (in some cases, spontaneous rotation takes place, although this is rare), and the labor is quickly terminated.—*Med. and Surg. Reporter*.

#### Carbon Monoxide, and Pregnancy.

A debated point in animal physiology is the question whether carbon monoxide can pass from the maternal to the foetal circulation. The influence of the subject outside the sphere of pure physiology is small but important. Accidentally or suicidally, a pregnant woman may have succumbed from the respiration of fumes from burning charcoal. Can the life of a viable foetus be saved by the timely aid of a Cæsarean operation? From his investigations on rabbits, M. Hogyes has answered this question in the affirmative, since he was unable to detect the gas in the foetal circulation by means of a spectroscope. MM. Gréhant and Quinquaud, however, conclude (see "*La France médicale*,") that in small quantities carbon monoxide may pass over from the maternal to the foetal blood.—*Lancet*.—*N. Y. Med. Jour.*

#### Management of Labor in Copenhagen.

Prior to 1877 a purely expectant plan was pursued in the management of labor at the Maternity Hospital in Copenhagen. If delivery was not accomplished within three hours, then resort was had to extractive measures. Since September 1, 1877, the method of expression has been employed in every case. In comparing the results obtained in two periods of four years each, by the old and new methods (1,780 of the former, and 1,559 of the latter), Dr. WEISS states that: 1. The frequency of hemorrhage occurring during the period of delivery has been markedly reduced. 2. Retained placenta has been met with much less frequently since the method of expression has come into use. 3. Rupture of the membranes has occurred more often. 4. Post-partum hemorrhage is now of very rare occurrence. In view of these facts, the author thinks that midwives should always be instructed to manage labor in this way.—*Le Courrier Médical*.

## DISEASES OF WOMEN.

**Etiology of Endometritis Fungosa, especially the Chronic Hyperplastic Endometritis of Olshausen.**

Dr. BREUNECHE (*Archiv für Gynäkologie*), states that his intention is not so much to add to the pathological and histological knowledge of this affection as to throw some light upon the origin of this form of uterine disease. For a long time all forms of fungous growths associated with metrorrhagia, and sometimes with purulent discharge, were grouped together under the one name, endometritis fungosa. Later, Olshausen separated the various forms somewhat, and Bischoff divided them into four anatomically different affections: (1) that form consisting of cedematous normal tissue, and granulation tissue rich in vessels; (2) the decidual form; (3) the diffuse adenoma; and (4) the diffuse sarcoma. Bischoff's third and fourth forms are evidently nothing but the chronic hyperplastic endometritis of Olshausen, divided into these two categories only because in the one case the uterine glands prevail, in the other the intercellular substance, but clinically the same. So Ruge distinguishes a glandular and an interstitial form, and a mixed form between the two. The author accepts the distinction, but claims that it does not depend upon any essential difference in the disease itself, but upon the age of the patient. The older the patient the more does the glandular form prevail, while with younger persons the intercellular form is most marked. To illustrate this view, and as groundwork for conclusions as to the ætiology, Breunecke gives the history of six cases. The first and third cases, occurring in women fifty and fifty-one years old, were markedly of the glandular form; the

second and fifth, aged thirty-one and forty-three, of the interstitial type. The mixed form occurred in cases four and six, in patients forty-eight and twenty-six years old.

As regards the ætiology, the author first notices as common to all the cases that before the profuse hæmorrhages characteristic of the disease, there were irregularities of the menstruation. From this fact BREUNECHE draws the conclusions that the first factor in the case is functional disturbance on the part of the ovaries, characterized by a retardation of ovulation. As a result of such retarded or difficult ovulation, we have congestion of the uterine mucous membrane, not sufficient, however, to cause rupture of the blood-vessels. Such congestion, unrelieved by hæmorrhage, leads to hyperplasia of all the elements constituting the uterine mucous membrane. When the repeated congestions finally lead to the rupture of the blood vessels, we have a mucous membrane which would favor profuse and long continued hæmorrhage.

This condition of impaired function of the ovary occurs naturally at the climacterium; hence most of these patients are at or past the menopause. It is known that Graafian follicles may ripen after the cessation of menstruation, and it is fair to suppose that the gradual thickening of the albuginea preventing the most of such ripening follicles from bursting the resulting congestion may be only now and then relieved in the way described. A similar effect is produced in younger persons by any weakening influence affecting the general health, or the sexual organs in particular.

As regards prognosis and treatment, the following may be said: The curette must be the chief method of treatment. After this, the restoring the

lost energy to ovulation, general tonic treatment must be adopted, and in proportion as this is successful will relapses be infrequent. This applies to those cases where the anomalies of menstruation are due to general debility. When, however, physiological or pathological changes of structure in the ovaries are present, the prognosis must be more guarded. In these cases, either all stimulus on the part of the ovary must be prevented, or the results of this stimulus, the hypæmia of the mucous membrane, be neutralized. For this latter purpose the constant use of glycerine tampons is of great service. The author condemns the use of caustics, as it is his opinion that neither is this change in the mucous membrane of a malignant character nor does it tend to become malignant. In accordance with this theory, if a case should threaten to terminate fatally, he would remove the ovaries rather than the uterus.

The author finally says that he by no means considers every case of fungoid growths accompanied by metrorrhagia as of ovarian origin. They may occur as a result of various local uterine troubles, as chronic catarrh, marked retroflexion, stenosis of the os internum and small fibroids. As characteristic of the ovarian form are the irregular menopauses which precede the hæmorrhages, the tendency to recurrence, and the greater quantity of fungoid masses brought away by the curette.

The type of fungoid degeneration connected with abortion, the author thinks, is characterized by remains of the decidua vera, and the observations of Lüstner and Ruge confirm this view. At the end of the article is a table which shows the anomalies of menstruation before and in consequence of the three following forms of endometritis: (1) endometritis hyperplastica ovarialis; (2)

endometritis fungosa or hyperplastica uterina; and (3) endometritis decidua. — *Boston Med. and Surg. Journal.*

#### Diseases of Gartner's Canals.

BÖHM (*Centralbl. f. Gynäk.*) considers that a pathological interest attaches to these functionless remnants of foetal life, in that they may become diseased, either independently, or in connection with inflammations of the vagina, vulva, or urethra. This fact has been observed by him in a number of cases, the canals having undergone a sort of diverticular dilatation, while they were discharging a more or less abundant secretion, of the consistence of cream. The edge of the orificium urethræ also showed evidences of inflammation, as well as the gland-containing depressions in the mucous membrane surrounding that orifice. The treatment consisted in the application of astringent solutions, and in one case it was found necessary to divide the tissues. The trouble is likely to be confounded with gonorrhœa, especially when the canals open into the urethra. — *N. Y. Med. Jour.*

#### Plantago Lanceolata as a Styptic.

The plantain juice does not contain tannin, but Professor QUINLAN (*Phar. Jour.*, No. 637) has derived excellent results from its use (chewed form or dried leaves) as a styptic application in external hemorrhage and internal bleeding from lungs, kidneys and bowels. In menorrhagia he has had fair results from large and repeated doses of the juice, either fresh or mixed with alcohol or glycerine. — *Med. & Surg. Reporter.*

#### A New Uterine Supporter.

As a means of giving tone to the vaginal walls, supporting the uterus, curing

leucorrhœa, and preventing intercourse, Dr. H. S. HUMPHREY recommends the use of the following powder, in the *Medical Age*: R. Amyli; sacch. alb., āā ȳj; finely pulv. chloride of sodium, 3j. M. Triturate thoroughly and put in a bottle; cork tightly. A large speculum is introduced, Douglass' cul-de-sac packed, and as the speculum is withdrawn, the vaginal walls are well smeared with this powder.

[Unless our memory of the anatomy of the pelvic organs is at fault, it would be difficult to pack the Douglass cul-de-sac through a vaginal speculum or any other way, in the living subject.]

A. J. C. S.

#### Treatment of Recto-Vaginal Fistulæ.

In cases in which the fistula is situated not more than an inch above the anus, Dr. MONOD incises the perineum up to the seat of injury, freshens the edges of the fistula, and then closes the wound by deep sutures passed from the vagina. In order to insure success, he recommends that, prior to the slitting up of the perineum, a stick of nitrate of silver be introduced into the fistula and passed carefully around its entire circumference. By this means the edges are whitened, and can be easily recognized during the operation.—*Centralblatt für Gynäkologie*.—*Med. Record*.

[This method of operating is certainly a questionable one. There is always danger that the sphincter ani muscle may not unite, and if that follows, the condition of the patient is far worse than she could be with a recto-vaginal fistula.]

A. J. C. S.

#### Menstruation after Extirpation of the Ovaries.

In reference to menstruation after extirpation of the ovaries, the following

professional opinions have been lately given (*Am. Jour. Obstet.*): Dr. CAMPBELL, of Ga., does not deny the influence of habit, periodical plethora, the ovaries and the Fallopian tubes, but he thinks there is a certain endowment of the nervous system. Dr. Goodell puts it that there is an irritation of the nervous bulb. Dr. Emmet had a case in which both ovaries were removed together with the Fallopian tubes, and yet there had been a regular menstruation thirteen times. Dr. Thomas said, as a rule, if the ovaries are removed, menstruation is the exception. If it occurred, it was due to metrostaxis. The only benefit of Tait's operation, over Battey's, was that all the ovarian tissue was more likely to be removed. Dr. Byford believes that in many cases some of the ovarian tissue was apt to be left; that it is difficult to remove all of said tissue.—*Weekly Med. Review*.

[Experience in removing the ovaries is drifting authorities towards acceptance of the facts stated by us some time ago, viz., that the ovaries are absolutely necessary to the establishment of menstruation, and if the menses recur for a time after the ovaries are removed it is due to a constitutional habit.]

A. J. C. S.

#### Extirpation of Cancerous Uterus.

Dr. A. REEVES JACKSON opposes the extirpation of a cancerous uterus, and states (*Am. Jour. Obstet.*): 1. That diagnosis of uterine cancer cannot be made sufficiently early to insure its complete removal by extirpation of uterus. 2. When evidence can be established, there is no reasonable hope of effecting a radical cure, and other methods of treatment far less dangerous than excision of the entire organ are equally effectual in the amelioration of the suf-

fering, and retard the progress of the disease and prolong life. 3. Extirpation of the uterus is highly dangerous and never lessens suffering except in those whom it kills, and does not give a reasonable promise of recovery, and should not be adopted in modern surgery.

[The above coming from one who possesses the sound judgment and mature experience of Dr. Jackson is most valuable. We hope that this will be carefully studied by the multitude of gentlemen who operate.] A. J. C. S.

#### Pelvic Peritonitis and Cellulitis.

Dr. GARNETT in an article on the advantages of drainage in suppurative pelvic peritonitis and cellulitis (*American Jour. of Obstetrics*), puts it that a very large proportion of women who are daily treated for uterine displacements, ovaritis, endometritis, or cervicitis, and who are thus permitted to drag along a suffering existence with temporary alleviations, are in reality the subjects of either parametritis, peritonitis, or some form of inflammatory exudation embracing greater or less areas of abdominal or pelvic space.—*Ibid*.

#### Antisepsis in Ovariectomy and Battey's Operation—Eighteen Consecutive Cases—All Successful.

Dr. ROBERT BATTEY, of Rome, Ga., contributes an article on the subject to the August number of the *Virginia Med. Mo.*, which concludes as follows:

It will be seen from the brief history given, that these cases were for the most part favorable ones, but not without complications. They were not selected at all, but each case was operated upon as presented.

The antisepsis was not strictly Liste-

rian. It consisted in the use of the spray by a very superior German instrument, long used by Mr. Lawson Tait, of Birmingham, England, who was kind enough to offer it to me on my visit to him in 1881, that I might "bring it to America just to show how not to do it," as he pleasantly remarked. I find this atomizer an admirable apparatus; it throws an ample spray to a long distance, and it will maintain it for two hours. I use a two-and-a-half per cent. solution of carbolic acid, and the same for instruments and sponges, which are kept constantly immersed. Carbolized silk is alone used for ligatures and sutures. Precaution is observed that only clean and pure hands touch the abdomen. The greatest care is used in the purification of instruments and sponges. The wound is dressed with carbolic cerate surmounted by a mass of loose raw cotton and flannel bandage.

It is a notable fact that since my last visit to Europe, the success of these operations in my hands has markedly improved. Why is this? In looking the ground over, I find myself at a loss to attribute the gain to any one thing. Without entering upon the discussion of the vexed question of bacterian influences, it is a well-settled fact that a good, pure atmosphere is a most valuable aid to successful surgery. An observation of thirty-five years in this mountain region of Georgia, has fully satisfied me that wounds of all kinds, without antiseptics, heal with a promptness and absence of complications which I have nowhere else observed, either in America or in Europe.

It has been my habit, and still is, to lay aside the so-called "dignity of the profession," when occasion arises, and to take hold with my own hands and assist in nursing any and every way that the safety of my patient may require.

Experience and skill in this operation certainly should have high rank in estimating the chances of success. To neither of these, however, can the sudden and marked alteration in my results be attributed. I am myself inclined to look first to the observance of *extreme cleanliness* in hands, instruments, sponges, bedding, furniture, etc.; second, to the discarding of the *écraseur*, as an instrument full of crevices for the lodgment of filth, very difficult to clean, and full of danger to the patient; thirdly, the use of hæmostatic forceps, which materially shorten the time of operating, save blood, and lessen shock.

Of the spray and the use of carbolic acid in general, whilst I think it has been pretty clearly shown by Keith, Bantock, and Tait, that neither is essential to the highest success, and when strong may even prove poisonous to patient and surgeon, I feel assured that weaker solutions do no harm, and think they may serve to guard the patient against any slight imperfections in the details of cleansing. Quite sure am I that my own results, with the acid and the spray, are now as good as I could desire. Let those who can get the same results without these aids do so—for myself, I am content to hold them as valuable assistants until their utter uselessness has been more conclusively shown.

My experience has been uniform upon one point, namely: when I have yielded to the solicitation of a patient, and operated at her distant home, leaving her in the hands of her family physician, the convalescence has been unduly slow and not satisfactory. In a few cases, they have gone beneath the sod when I could but feel that they might have been saved.

The friends of a patient are by no means the best nurses for an ovariectomy case. Whilst in England I was assured

that no operator who had any character to lose would venture to stake it upon an operation to be done under such disadvantages. They all require their cases to come to them, and put them into the hands of their trained nurses.—*Ibid.*

#### The Influence of Worry and Nervous Shock on the Uterus and its Functions.

Clinical lecture by WM. GOODELL  
(*Med. and Surg. Reporter*):

This lady is 37 years old. She has had four children, the youngest of which is nine years old. Her trouble began twelve years ago, but has been worse since the birth of her last child. She complains of pain in the back and head, fluttering of the heart, cold hands and feet, irritable bladder, wakefulness, and when she does sleep has bad dreams, which wake her in a fright.

What is the meaning of these symptoms? They are nervous symptoms. We must decide whether they are due to a local or constitutional disease with a constitutional expression, or whether to a pure nervous trouble. In the first place, I ask her whether she has had any trouble in her family. She tells me that she has had no trouble; she has had a happy home and no cause of worry.

I have a patient who often comes to see me, complaining with these nervous symptoms, and I have repeatedly told her that she must have had some cause of worry or of nervous shock, but she has always denied any such cause until a day or two ago, when she said that possibly a passage in her history might explain the trouble. She said that her father had softening of the brain and became insane, but the insanity was of a passive type. He had never done any one harm until one day when she entered his room, he made a spring at her,

and she saw from his expression that he was going to do her harm. She seized some heavy article, exclaiming, "Father, if you come near me, I shall throw this at you," and looking him steadily in the eye, he quailed. In order to get out of the door, she had to turn her back towards him; and the instant she did this, he sprang and caught her and tried to bite and injure her. She shrieked for assistance, which fortunately was at hand. This fright made such an impression upon the nerve centers that from that time she was never well. This was the foundation of her troubles, although she thought that it had nothing to do with them.

I have had a patient under my care for seven months, suffering from menorrhagia and these nervous symptoms, in whom the trouble was caused by the throwing of a dead cat into her lap. You may ask, how can a dead cat produce menorrhagia? or, in other words, how can a fright produce menorrhagia? It does it in this way. It produces a profound impression upon the nerve-centers, and there is no longer that correlation of nerve-power which exists in health. The nerves behave as they please. There is irregular distribution of nerve fluid; this leads to irregular distribution of blood; more blood goes to one organ than to another. The most exacting organs during the woman's menstrual life are the womb and its annexes, the ovary, the vagina, the erectile tissue around the womb, the broad ligaments, and the fallopian tube. They receive more blood than they should. There is increased nutritive action, vegetations develop, and the womb increases in size. In the lady of whom I have spoken, I was unable to cure the menorrhagia. I used the curette and could control the hemorrhage for a time, but it would always re-

turn, and ultimately I removed both ovaries. These organs were found to have undergone follicular degeneration.

I shall now make a vaginal examination. I examined her once before, but did not think that any operation was required. There has been a laceration of the cervix and of the perineum, but these lesions do not usually produce such severe symptoms. She has worn a pessary, but it always caused pain. I must honestly say that I dislike to subject this woman to an operation when I am by no means positive that it will do her good, but I shall do something which I think will modify and tone up the condition of the womb. The sound gives a measurement of three inches. There is no ectropion of the mucous lining of the cervical canal, and that is one reason why I think an operation is not indicated. To-day I shall curette the womb.

Is there any danger in the use of the dull curette? This is an important question, for you will frequently do the operation in your office. I have never lost a patient from the use of the curette, but I have occasionally had some inflammatory disturbance.

There has been a little bleeding following the passage of the sound. I shall first introduce the blunt curette. I remove several vegetations. A few of these are quite large. These little fungous growths are entirely benign. I have often told you how unreliable the microscopical examination of uterine growths is. The best microscopists have told me that certain growths were epithelioma, when the subsequent course of the case has proven that the disease was perfectly benign. I lately came across a passage in the works of a German writer in which he says that it is one of the most difficult things to decide between benign and malignant

growths of the womb by the microscope. The alveoli of innocent growths simulate very closely cylindrical epithelioma. I think that this is the reason that microscopists have been misled.

Having removed so many of these vegetations, I shall go over the endometrium with the sharp curette. This is an instrument I do not advise you to use at first, for your fingers are all thumbs, and you cannot manipulate with the delicacy that is necessary in employing this instrument. I first dilate the canal with Ellinger's dilator, in order that the instrument may readily enter; and then, taking it as I would a pen, I gently pass it into the cavity of the womb. I can hear and feel the curette passing over the rough vegetations. The lining of the womb should be perfectly smooth. Having removed all the vegetations, I shall make an application of strong tincture of iodine to the fundus. She will then be put to bed, and if necessary receive an opium suppository.

What shall we give this patient, internally? If she were rich enough, I should put her to bed, have her well rubbed, and electricity applied. She cannot do this. The next best thing is to give some remedy to tone down these nerve-centers which are not behaving themselves. I should like to give her the valerianate of zinc and quinia, which, take it all in all, is the best combination which we can give. I shall order a triple valerianate as follows: *R. Zinci valerianatis, quiniæ valerianatis, ferri valerianatis, 3̄ gr. xx. M. et ft. pil., No. xx. Sig. One, three times a day.*

After a time, I shall give strychnia in small doses, gradually increased. She would, I think, be benefitted by the use of malt. Keasbey and Mattison make a good preparation. Of this, she will

take a tablespoonful three times a day in milk. It is a good plan to take one dose of the malt at bed-time. This favors sleep. (The patient was now removed.)

I tell you frankly that I do not believe her statement that she has had no trouble; I believe that she has some cause of worry which has aggravated this, for there is not sufficient local trouble to account for the constitutional symptoms.

To illustrate this, let me refer to a case which I saw the other day. A young girl was sent to me with the history of dysmenorrhœa, and all the train of nervous symptoms which the patient before you to-day exhibited. I examined her and, as a matter of course, found antelexion, but the sound passed readily. The dysmenorrhœa had developed within a few months. I asked her if she had studied hard at school. She said that she had, and had been compelled to leave school. She stated that she had no cause of worry. After she had left the room, the lady who came with her told me that the girl's father, although a good man, was an intemperate one, and that his intemperate habits worried the girl very much. In the great majority of such cases a cause for worryment will be found.

#### Amenorrhœa.

Dr. T. L. HATCH, in discussing different remedies for this condition, insists upon the necessity of judicious selection of remedies adapted to special cases. He says that in suppressed menstruation from nervous shock he has found the best results from the following formula: *R. Ex. nucis vom. fl., m xx.; aquæ, 3̄ iv. M. Sig. Teaspoonful four or five times a day.* This is particularly indicated if there are colicky pains in the abdomen.

In these cases of shock, if there is sensitiveness to noise and much restlessness,  $\frac{1}{10}$  grain caffen every three or four hours acts like a charm, relieving nervousness and jactitation, and in a few hours restoring the suppressed function. In some cases of suppression from shock, pulsatilla is the best remedy. It is specially so in the case of blondes who are disposed to be phlegmatic. Suppression from catching cold will generally be relieved by aconite, pulsatilla, gelsemium and ipecac. If there is much fever, with rapid pulse, aconite alone, carried to the full sedative effect, will usually be sufficient, but sometimes it will have to be aided by some remedy like pulsatilla, ergot, macrotys, or nux vomica, to act as a nerve tonic.

Gelsemium is indicated when there is much pain in the back and head, with pinched features, and bright, sparkling eyes, or any disturbance of vision: *R.* Ext. gelsemii fl. (green root), gtt. x-3 j.; aquæ,  $\mathfrak{z}$  iv. *M.* Sig. Teaspoonful every hour.

If there is dryness of the skin or much leucorrhœa, ipecac, kept just within the bounds of nausea, will be the remedy. He thinks macrotys is indicated oftener than any other remedy, especially when there is a relaxed debilitated condition of the organ, or when the patient has caught cold and the circulation has been regulated by the appropriate remedy. — *Therapeutic Gazette.*

#### Value of Leiter's Coils in the Treatment of Peritonitis.

(Dr. JAMES B. HUNTER, *Med. Record.*)

A young married lady, in perfect health, while bathing in the surf, was thrown with some violence against a post, striking the right arm and side. This was August 1st. The next day

she suffered pain in the arm and a little soreness in the right side, but did not keep her bed. When first seen, on the sixth day, she was unable to move in bed without much pain in the right side of the abdomen, and she had extreme tenderness over a distinctly circumscribed space. She said the pain had been increasing every day since the accident. There was not the slightest discoloration or appearance of a bruise on any part of the body except the arm. There was some vomiting, with constipation and tympanites. The temperature was  $103^{\circ}$  and the pulse 110. An enema was given to relieve the bowels, and aconite, followed by quinine. The latter drug was given in five-grain doses every two hours, but the temperature continued to rise steadily until it reached  $105^{\circ}$ , where it remained in spite of quinine, cold-sponging, and ice-bags on the head, for thirty-six hours. The evidences of peritonitis being confined to one side, a Leiter's coil, six inches in diameter, was placed on the side, and firmly bound there by a roller bandage. In four hours after the application of the coil, with a current of ice-water passing through it, the temperature had fallen to  $102^{\circ}$ , and in eight hours to  $100^{\circ}$ . The temperature of the water passing through the coil was increased to about  $50^{\circ}$ , and in twelve hours from its application the patient's temperature had fallen to  $99^{\circ}$ . The coil was removed, and in three hours the temperature went up to  $103^{\circ}$ . The coil was replaced, and it again fell to  $99^{\circ}$ . A second time, after twelve hours, the same experiment was tried, with the same result, the temperature reaching  $103\frac{1}{2}^{\circ}$ , and having an evident upward tendency. With these exceptions, the coil was in position for two days and nights; after which time its removal was followed by a rise of only a degree, and

its use was discontinued, the patient making a good but slow recovery. Ice-bags to the head were used at the same time with the coil. The water passing through the tube was sometimes ice-cold and sometimes only about 50°. The patient found the coil agreeable, and disliked to have it removed. The sensation of cold was decidedly pleasant, the greater part of the time. When it was not so, the lump of ice was taken out of the bucket that supplied the coil, and the effect was no longer complained of. A soft handkerchief twice folded was placed between the lead coil and the skin. There was good reason to believe that an attack of general peritonitis was prevented in this case by the method adopted for reducing the temperature. Its use earlier would probably have saved the patient several days of suffering.

## DISEASES OF CHILDREN.

### How to Bring Up Infants.

Mr. EDMUND OWEN, F.R.C.S., of London, gives the following instructions to out-patients:

*What Food to give.*—Mother's milk is the proper food for babies, and until they are three or four months old they should have nothing else. But if that cannot be got, or be not sufficient, cow's milk, fresh, two or three times a day, and from the same cow, and not scalded, is the next best food; but it must be freely diluted, as it is much too "strong." The bottle should be filled with a mixture of cow's milk and warm water, in which a lump of white sugar and a very small pinch of salt have been dissolved. For the first few months there should be more water than milk—perhaps *twice as much water as milk*—

and, as the babe thrives, the proportion of milk may be gradually increased. *No other food* should be given before the sixth month; baked flour, arrowroot, and oatmeal cannot be digested, so they cause sickness and diarrhœa.

*When to give it.*—For the first month a baby should be fed every two hours, and, by gradually increasing the interval, he is in time fed every three, and, eventually, every four hours. He should not be fed because he cries; very likely he is in pain because his stomach is overloaded. When he is sick after his milk he should be fed for a less time and at shorter intervals, and, if the bottle is being used, a larger proportion of water must be tried; and, if he is a fair sleeper, he should be woke up for his regular meals, and never allowed to over-feed. A tablespoonful of lime-water may be added to each bottleful of food, and especially so in summer.

*How to give it.*—The best kind of feeding-bottle is the old-fashioned, long, straight one, with a short India-rubber teat and with no tube at all. The very worst kind is that with the long India-rubber tube. There should be two bottles—one for day and one for night; after being used, the bottle should be thoroughly washed in hot water in which a little soda has been dissolved, and should then be well rinsed in cold water. Till next wanted it should be kept in a basin of clear cold water. When six months old the baby may be allowed, in addition to milk, boiled bread and milk, oatmeal, Robb's biscuits or Chapman's wheat flour.

*Weaning.*—As a rule, when the baby is about nine months old the mother should begin to wean him by giving him less of the breast or bottle, and more of the cow's milk and of the foods just mentioned, and, in addition, a little beef-tea, or meat-broth, and soaked

bread. At a year old the child must not be entirely weaned, and soon he must have daily a little under-cooked meat pounded up into a pulp, and to which a little gravy and salt are added; some potato finely mashed and covered with gravy; an egg, or a little milk-pudding. On no account should he be allowed any wine, beer, tea, or coffee, though he may have cocoa and milk. He should be given his meals regularly, and he should not be allowed to "pick" at bread and butter, cakes, and sweet stuff in the intervals. Children flourish best on fresh foods. The worst-nourished patients that I see at the hospital for sick children are those reared on Swiss milk and various patent foods. *Rule.*—Do not give a baby food or physic that is advertised.

*Clothing.*—Babies and little children must be kept always warm. They cannot be "hardened" by scanty clothing or cold baths. Their necks, thighs, legs, and arms need to be covered as well as their chests and bodies; they should wear long sleeves and stockings, and, when old enough, cotton or flannel drawers.

*Fresh Air.*—Children should be taken out of doors each day that the weather is fine. If they are sent out in a perambulator, care must be taken that the feet and legs are warm to start with, and that they are so well covered throughout the ride that they are warm on the return home. Every day, unless a bitter wind is blowing, or it is foggy, the windows should be opened for a while, for fresh air is as necessary for children as fresh food.

*Sleeping.*—At night if a child perspires freely or kicks off the bed-clothes, he should wear a flannel bed-gown long enough to be tied below his feet, and the bed-clothes must be securely tucked in. He should not be rocked or patted to make him sleep; sleep should come

naturally, and, like the food, at regular intervals.

*Bathing.*—Morning and night he should be washed all over in warm water, but should not be exposed long enough to feel chilly afterward. A handful of sea-salt, thoroughly dissolved, may be added to the bath. Except in the very warmest weather no little child should be put in a cold bath.—*N. Y. Med. Jour.*

#### Infant Foods.

Dr. ALBERT R. LEEDS thus concludes an article in *Med. and Surg. Reporter*:

I have been frequently asked why I do not publish my own opinion as to the best of the various infant foods now in use. To do so would be very unwise for many reasons. But I have endeavored to do what I have regarded as of far more importance than this, which is to praise or blame just as the information afforded by physical and microscopic examinations and chemical analyses demanded, without partiality or bias, and to seek out and state the principles upon which, as it appeared to me, the dietetic value of these articles of infant food depended.

To summarize the points which I have endeavored to establish:

1. Cow's is in no sense a substitute for woman's milk.
2. Attenuation with water alone is inadequate, and chemical metamorphosis, or, mechanically, the addition of some inert attenuant is required, in order to permit of the ready digestibility of cow's milk by infants.
3. The utility of manufactured infant's foods is to act as such attenuants, and as such they take the place of the simple barley and oatmeal water, the sugar, cream, baked cracker, arrowroot, etc., etc., used in former times.
4. The results of both chemical and

physiological analysis are opposed to any but a sparing use of the preparations containing large percentages of starch.

5. It is eminently probable that besides acting as attenuants, the matters extracted in the preparation of barley and oatmeal water, and still more the soluble albuminoid extractives obtained at ordinary temperature (whereby coagulation is prevented), by Liebig's process, have a great value of their own. For this reason, instead of employing starch, gum, gelatine, sugar, etc., the use of natural cereal extractive, containing saccharine and gummy matters and soluble albuminoids as well, such as our great and inspired teacher Liebig himself advocated, is in accordance with the developments of science since his time.

6. The use of a food made up of equal parts of milk, cream, lime-water, and weak arrowroot-water, as practiced for years by the late Dr. J. Forsyth Meigs, and recently advocated by his son, Dr. Arthur V. Meigs, is sustained by theory, analysis and practice. It provides for the increase of fat to an amount comparable to that contained in human milk. It adds alkali to permanent reaction, and to convert caseine into soluble albuminates, it adds a little bland attenuant. And if, in addition, the amount of milk-sugar were raised, and instead of arrowroot water, barley or oatmeal water were substituted, as the case demanded, it would approach, it appears to me, still more nearly to the conditions required.

7. The perfect solution of the present problem is to be found in the modification of cow's milk by chemical processes, so as to make it physiologically equivalent to human milk. The nature of these processes, and the results to be obtained, are at present so nearly

wrought out, that there is good ground for believing that such a solution of this problem is not far distant in the future.

#### The Feeding of Infants.

Dr. V. POULAIN believes that the reason that cow's milk so often disagrees with children is to be found in the fact that cane-sugar is used to sweeten it. In the *Brit. Med. Jour.*, he says that for thirty-three years he has used the sugar of milk with the best results.—*Ibid.*

#### Disseminated Sclerosis in Children.

The *Medical Times and Gazette* says: The absence of any mention of this affection, in the leading text-books on the diseases of childhood, has induced M. MARIE to investigate the literature of the subject; and the result of that inquiry is the collection of fourteen published cases in which a diagnosis of disseminated cerebro-spinal sclerosis has been made in children. The majority of these have been recorded in this country; a large proportion of them will be found in our pages during the years 1877 to 1879. The characteristic symptoms are the same as in adults, the most important being trembling on voluntary movement, usually first noticed in the legs, and generally accompanied by exaggeration of the tendon reflexes. Strabismus and nystagmus were frequently present; and affections of speech were almost constant, the speech becoming slow, monotonous and measured; occasionally trembling of the tongue was noticed. A certain amount of mental disturbance was usually present, *e. g.*, irritability of temper, impaired memory, or weakened understanding. Epileptiform or apoplecticiform seizures were present in some of the cases. Affections of common sen-

sation were but seldom present. In most of the cases the disease came on quite early (about the age of four years), and in one or two may have been congenital. We should exclude M. Charcot's patient altogether, as the patient was fourteen before any symptoms were recognized, and it therefore cannot fairly be grouped with cases in which the disease commenced in childhood. In several instances the disease seemed stationary, in some was slowly progressive; in one instance the patient completely recovered, but had a relapse afterwards consequent upon a fright. In only one case did death occur. The patient in this instance was a girl of fourteen, who had first presented symptoms of nerve disorder seven years previously, strabismus, diplopia, and left facial paralysis being the first indications. Two years later, paralysis came on, and became general, but was not persistent. Mental changes commenced about the same period, and from this time the intellect progressively deteriorated. There was marked incoördination of movements before her death, but no evident muscular wasting. On examination there was found increased resistance of the brain substance, due to affection of the central parts, and not of the cortex, the whole of the corona radiata being involved and altered in consistence; the crura cerebri, crura cerebelli, and pons were also more resistant than natural, and this was more marked on the right side than the left. In the spinal cord, the posterior columns were most affected, and next the lateral. Microscopically, a process of sclerosis was found to be going on in the affected areas, and it was especially noted that the changes were most obvious around the blood-vessels, which themselves had undergone some cell-infiltration. The writer is of opinion that the irregular

distribution of these patches of sclerosis justifies him in considering the case to be one of disseminated rather than diffuse sclerosis. M. Marie has endeavored, in the paper we have been analyzing (*Revue de Médecine*), to show that disseminated cerebro-spinal sclerosis may occur in children with the same symptoms and pathology as in adults. We feel bound to confess that we do not think he has succeeded in proving his position. Out of the fourteen cases he has collected, only one proved fatal, and there was found a diffuse, or at any rate a widespread, irregular sclerosis of the white matter of the brain and spinal cord, the grey matter apparently being uninvolved. This is not quite in accordance with what is usual, nor do we consider that the symptoms and course of the disease in many of the cases were such as would exactly tally with a case of disseminated sclerosis. These cases however, appear to us all to belong to the same group, but we consider that further pathological evidence is required before they should be classed as of the same nature as disseminated sclerosis in adults.

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#### OBSTETRICS.

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##### New Reasons for Woman's Nursing.

A new element has been discovered by M. BECHAMP in woman's milk, hitherto unknown, which in a striking manner dissipates the obscurities of the empiricism on certain points of maternal nursing.

It results that woman's milk differs essentially from the milk of the cow and the ass, not only in density, the quantity of milk sugar, of butter, of salt and water, but by the presence of a special and specific ferment, which modifies

considerably its digestive qualities or digestibility.

This ferment is called *zymase*; its history is closely connected with that of the microzymas, which biologists consider an integral part of all normal tissues. These microzymas, when diseased, are converted into bacteria and give rise to diseases in general.

The *zymase* of woman's milk possesses the property of saccharifying the starch, a phenomenon for the first time signalized, and which is not produced in the milk of the cow, the ass, or other mammalia.

Cow's milk contains, besides caseine, two distinct albuminoid materials; one of these remains soluble in water, after having been precipitated by alcohol; this is the *galactozymase*, a substance capable of solidifying the starch of the feculæ, but without saccharifying the amylaceous material, while *zymase* of woman's milk saccharifies the feculæ.

In order to test the saccharifying property of *zymase*, proceed as follows: Woman's milk being normally alkaline, acidify mildly with acetic acid, add at least three times its volume of alcohol of 90°. The very voluminous albuminous precipitate is collected in a filter, washed with dilute alcohol (in order to remove the milk and sugar), and again with ether (in order to remove all fatty matter); and again add distilled water. After filtering, the solution possesses in the highest degree the property of fluidifying and saccharifying the feculent starch.

The results are always the same, whether the milk had been long in the breast; or the milk taken immediately after nursing; or after it had nursed a second time, or even half an hour later.

Consequently woman's milk contains an entirely different *zymase* from cow's milk; and since the milk taken in differ-

ent stages of nursing is endowed with the same activity, it must be clearly a natural product of the mammary gland, and not the result of a chemical change in the milk in consequence of stagnation in the gland.

This discovery has an important physiological and pathological bearing upon the specificity of the organs, and upon the idiosyncracies of the nurse. It demonstrates that the secretory product of a glandular organ of a similar anatomical character, differs according to the species and object to be attained, without depending absolutely upon its texture.

The practical consequences of the discovery that the *zymase* of woman's milk is capable of saccharifying the starch will not be slow in making itself felt in the practice of nursing.

In the first place, it is evident that woman's milk cannot be replaced by any other milk, whether of the cow, ass, or dog. They are far removed from the milk of woman. The same may be said of the innumerable formulæ of artificial feeding.

In the second place, in the faculty of saccharifying starch of woman's milk, is found the explanation of the ancient usage of feeding of infants. Most of the preparations contain farinaceous or starchy matter. A nursing of 50 grammes gives enough *zymase* to make 50 centigrammes of gluten. The *zymase* and the saccharifying action of the saliva and the pancreatic fluid show a nursing infant has three secretory products capable of transforming the starch into glucose in a manner to facilitate its absorption.

The following are the conclusions reached: 1. Woman's milk contains a ferment of a nature to saccharify raw or boiled starch. 2. The specificity of woman's milk is due to the presence of

zymase, which makes it preferable to any other. 3. No equivalent can be found in the milk of cows, asses or dogs. 4. The milk of domestic animals may be taken, pure or mixed, in want of woman's milk, but it is never worth as much. 5. Infants should be breast-nursed in preference to all other kinds of feeding. 6. When infants have arrived at the age of taking feculent food, woman's milk may still be useful in aiding in transformation of starch into sugar.—*Paris Medicale.—St. Louis Med. and Surg. Jour.*

#### Diagnosis of Pregnancy.

M. LOVIOT (*Jour. de Med.*) considers that the diagnosis of pregnancy can be made with certitude even in the first three months before the fetal signs are present. He relies upon physical maternal signs revealed by palpation and the touch combined. By this means a tumor is recognized as being formed by the uterus modified by pregnancy. The superior segment of the uterus felt above the symphysis is a rounded, depressible elastic tumor. The inferior segment is lowered, flattened and enlarged, and forms around the base of the cervix, which is a protuberance, a characteristic ring. The consistence of the gravid uterus is soft, supple and elastic; gives to the finger on pressure the sensation of a rubber bulb. This sensation should be felt on all accessible portions of the uterus. M. Loviot avers that neither congestion, metritis, nor fibromata, even softened, give the same sensation. The presence of a fibroma along with pregnancy is no absolute bar to the diagnosis, for the notions of consistence will be sufficiently preponderant to fix the diagnosis surely. *Canadian Practitioner.*

#### Hot-Water Enemata in Delivery.

Dr. BECKINGSALE gives in the *Brit. Med. Jour.* the results of his use of hot water in labor: The value of hot-water enemata as a means of hastening delivery, apart from its use in the removal of fecal accumulation, in such cases of tedious labor in which either ergot or the forceps are admissible, has been hitherto unaccountably ignored in practice, as far as my experience extends. I formerly had warm-water enemata given with the usual object of removing fecal obstruction from the rectum; in most cases, an increased rate of dilatation of the os followed. Latterly, I have had enemata of hot, not merely warm, water administered, whether there were any appreciable collections of feces or not, and always with the result of an accelerated rate in the progress of labor. The fact of the os dilating under the influence of the enema, whether there was an appreciable quantity of feces or not in the rectum, proves that their presence does not prevent dilatation by causing spasm; at least, not in the majority of cases. It follows that the hot enema must act as a direct and powerful stimulant to the uterine muscle, and I feel convinced, I may add, as a result of close observation, also to the voluntary muscles engaged in the act of parturition. Judging from the sense of relief which follows its administration, it has, at the same time, a relaxing and soothing effect on these same parts; analogous, in short, to the effect of hot water applied in the familiar form of a fomentation to an inflamed and painful swelling.

I believe I am justified in adding that there is less atony of the uterus after delivery, when a hot enema has been given; and consequently less tendency to post partum hemorrhage. On this

account, it has not the after-relapsing effect of chloroform on the uterus, it otherwise commonly has.

I submit that it would be as well to give so simple a means of treatment as hot-water enemata a trial, in cases in which either ergot or the forceps would be used, as it possesses obvious advantages over both.

#### Rupture of the Vagina during Labor.

Dr. D. BERRY HART thus concludes a paper on this subject in the July issue of the *Edinburgh Medical Journal*:

1. During labor the uterine muscle exercises an upward tension on the cervix and pelvic floor segments.

2. The foetal head exercises a dilating power on the cervix and pelvic floor segments, this dilating force acting at right angles to the long axis of the cervix and vagina.

3. The vaginal walls are constructed so as to bear longitudinal tension and eccentric strain. This is provided by rugæ and the felted structure of the vagina.

4. The anterior vaginal wall, from its close incorporation with the urethra and loose union with the bladder, is the strong wall.

5. The posterior vaginal wall is structurally weak at its upper half-inch; is more elongated during labor than the anterior one, and therefore—

*Rupture of the vagina is most common where the posterior vaginal wall is covered by peritoneum, and when it occurs is a tension tear like cervical rupture.*

The precise conditions under which such a vaginal tear happens will vary with each case. The preponderance of the frequency of cervical over vaginal rupture is marked, and is due in part to the head entering the cervix. Finally, it is evident that a knowledge of the

force necessary to tear this part of the vaginal wall would give us a force under that necessary to complete a full-time labor.—*Med. and Surg. Reporter.*

#### Cardiac Ectopia.

Considerable interest was manifested at a recent *séance* of the Académie de Médecine of Paris, by the exhibition of a case of pregnancy at the ninth month, by M. TARNIER. The woman was a secundipara, and the sternum was bifurcated at the lower part, so that the beats of the heart were seen to take place immediately beneath the skin of the epigastric region. It was stated that the ventricular part of the heart could be seized between the fingers; by palpation over the upper part of the notch the contractions of the auricles could be detected. Apparently the diaphragm does not exist at the site in question. M. Marey said that this specimen of teratology would no doubt permit a verification in man of observations made upon the heart of animals. M. Beau had explained the beat of the heart as due to dilatation under the influence of the afflux of blood at the time of the ventricular systole. According to him the apex of the heart contracts during the diastole. In the case of ectopia, on the contrary, it was easy to perceive that the ventricle was soft during the diastole and hard during the systole; in the latter period the apex of the heart strikes the thoracic wall.—*London Lancet.*—*Med. Record.*

#### Delivery Prevented by an Enlarged Fœtal Spleen.

Surgeon-General CHAS. R. FRANCIS, of the British Army, reports in the *Medical Press and Circular* a very singular case which occurred in the prac-

tice of Dr. Webber, of Dinagepore, India: A well-formed, native female, æt. 20, was taken in labor with her first child, and attended by a native mid-wife. The labor had continued for several hours, when the civil surgeon was called, his services being desired owing to the cessation of all pains after the delivery of the head. The child was dead, but he corrected the position with facility, bringing the shoulders down and hooked down the arms with his fingers. In this position, traction was practiced for two hours without any advance. At this time the head became detached. The woman was then placed under chloroform and podalic version performed, but still without effecting delivery. It was decided to open up the child's abdomen, the distension of which was an obstacle to delivery. A guarded scalpel was introduced, and after the opening was made, an enormous and hard tumor was detected, which required to be broken up before it could be removed. The delivery was then easily accomplished, and it was then discovered that the tumor was an enormously enlarged spleen. The placenta came away in eight hours without flooding, and the woman made a complete, though slow, recovery.—*Md. Med. Jour.*

**Professor A. R. Simpson on Axis-Traction Forceps.**

This double property of the Tarnier forceps—of *first*, giving power of correct traction; and *second*, giving a guide to the proper direction—puts the obstetrician who uses it at a great advantage over the operator who has only an ordinary curved instrument in his hand. It is vain to tell us who have employed such axis-traction forceps that you can do so and so with the older instrument. We fancy we know pre-

cisely what we can do with that. We have used it in all imaginable cases, and have had recourse to the various manipulations recommended with the view of obviating the loss and misdirection of power that their construction involves. In the simple cases—and these, to be sure, constitute the majority of forceps cases—we have accomplished the delivery of the child to our perfect satisfaction, and without the expenditure of much strength or skill. But cases have sometimes met us that tried all our strength and taxed all our skill, that sometimes baffled us completely or were terminated by the extraction of a damaged child from a damaged mother. And now we find that the axis-traction forceps enables us to effect delivery in such cases with less expenditure of energy and with more precise direction of power; hence, not only with more ease and comfort to ourselves, but with more safety to the woman and child. Let who will continue to use ordinary curved forceps, an obstetrician who has used the Tarnier forceps in a few test cases will no more think of reverting to the other than a man who can afford to keep a carriage will continue to practice as a peripatetic. He may use the defective instrument occasionally, to keep muscle and mind in exercise, or because the case is so easy that it can be finished with anything, as he may walk to some patient's house for the sake of his own health, or because he lives in the same street; but in the general run of his work, and in all his difficult cases, the axis-traction forceps becomes for him a valued necessity.—*Edinburgh Medical Journal.*

